HOSPITAL BIRTH PLAN

Prepared by: [BIRTHING PARENT S FULL LEGAL NAME] (she/her) **Date prepared: Estimated due date: Planned birth location:** [PLANNED BIRTH FACILITY LOCATION], [STATE] **Primary provider:** [OB MIDWIFE PRIMARY PROVIDER NAME]

> ***To my care team:*** *This birth plan reflects my informed preferences for labor, delivery, and newborn care. It is not a contract and it is not a refusal of medical care in a genuine emergency. I understand that clinical judgment may require deviation from these preferences, and I ask that, wherever time and safety permit, I be informed of the reason and given the opportunity to give or withhold informed consent before any intervention. Preferences not reached by this document should default to the provider's standard of care under applicable professional guidelines.*

Decision-Making Authority (Read First)

If I am temporarily unable to make decisions, decisions should be made in the following order:

1. **My partner named above, in consultation with the care team**
2. If unavailable, my emergency contact.
3. Otherwise, the standard of care under the judgment of the attending provider.

If an emergency arises, I understand that the clinical team may act immediately to preserve my life and my baby's life, consistent with the Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. § 1395dd, and applicable state emergency-care law. I trust that where time permits, the team will seek my or my decision-maker's informed consent.

Patient Information

Field	Detail
Name	[BIRTHING PARENT S FULL LEGAL NAME]
Date of birth	
Address	[ADDRESS]
Phone	
Preferred language	English
Blood type	Not specified
Rh factor / antibody status	See prenatal records
GBS status	Unknown
Allergies	None known
Current medications	Prenatal vitamins
Relevant medical history	None
Prior births	None
Emergency contact	See support persons below

Support Team

- **Partner / co-parent:** None designated
- **Other support persons:** None

HIPAA Authorization

Pursuant to 45 C.F.R. §§ 164.508 and 164.510, I authorize the care team to disclose my protected health information, and the protected health information of my newborn, to my partner and the support persons named above, for purposes of coordinating my care and providing updates during labor, delivery, and the postpartum stay. This authorization may be revoked by me in writing at any time. This authorization does **not** permit disclosure to law enforcement, immigration authorities, or any third party not listed, except as required by law.

Labor Preferences — Hospital Delivery

1. Environment and Movement

- **Freedom of movement:** Free Movement.
- **Environment:** Dim lighting, quiet voices, personal music playlist, minimal non-essential staff in the room.
- **Non-pharmacologic comfort measures I want available:** Hydrotherapy, Position Changes, Birthing Ball, Massage, Breathing.

2. Monitoring, IV, and Intake

- **Fetal monitoring:** Intermittent.
- **IV / hep-lock:** Hep Lock.
- **Oral intake:** Light Food And Fluids.
- **Cervical exams:** Minimize.

3. Induction and Augmentation

- **Induction:** Avoid Unless Medical.
- **Augmentation (Pitocin / amniotomy):** Discuss First.

4. Pain Management

- **Plan:** Flexible.
- **Offering medication: Please do not offer pain medication unless I specifically request it.** I will ask if I want it.

5. Delivery

- **Pushing position:** Position Of Choice.
- **Pushing style:** Spontaneous.
- **Episiotomy:** Avoid.

- **Vacuum / forceps:** Discuss First.
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- **Who catches / receives baby:** Provider.
- **Umbilical cord clamping:** Delayed.
- **Cord cutter:** Partner.
- **Placenta:** Hospital Disposal.

6. Third Stage and Postpartum Hemorrhage Management

- **Active management of the third stage** (prophylactic oxytocin, controlled cord traction): [THIRD STAGE PREFERENCE].
- I understand that postpartum hemorrhage is a leading cause of maternal morbidity and I accept escalation — including uterotonics, TXA, bimanual compression, balloon tamponade, and transfusion — in the event of hemorrhage, subject to any separate refusal I have executed.

7. If Cesarean Becomes Necessary

If a cesarean becomes medically necessary, I want to be fully informed before consent, have my partner present, request a clear drape and delayed cord clamping where safe, and hold my baby skin-to-skin in the OR as soon as stable.

If a cesarean is performed, where clinically safe I request: a gentle / family-centered cesarean; a clear drape; arms free; EKG leads placed on back/sides to keep my chest clear for skin-to-skin; immediate skin-to-skin in the OR once baby is stable; my partner present in the OR; and delayed cord clamping where safe for baby.

Newborn Care and Procedures

| Procedure | My election | |---|---| | Immediate skin-to-skin | Yes — delay all non-urgent procedures | | Delay first bath 24+ hours | Yes (WHO recommendation) | | Rooming-in | Yes — baby stays with me | | Feeding plan | Breastfeeding | | Vitamin K prophylaxis | Accept Im | | Erythromycin eye ointment | Accept | | Hepatitis B vaccine at birth | Accept | | State newborn metabolic screening | Accept | | Newborn hearing screening | Accept | | CCHD pulse-oximetry screening | Accept | | Circumcision | Not Applicable | | Cord blood banking | None |

Newborn Identification and Security

I request standard newborn ID banding with matching bands for the birthing parent and my designated support person. Please do not remove my newborn from my room for any non-emergency procedure without informing me, and please accompany any off-unit transport with an ID check.

Feeding

My feeding plan is **Breastfeeding**. **Please do not offer formula, bottles, artificial nipples, or pacifiers to my baby without my explicit consent.** If supplementation becomes medically necessary, please discuss with me first and use cup, spoon, or syringe feeding where feasible. I request an in-hospital lactation consultant visit.

Newborn Metabolic Screening

I consent to the state-mandated newborn metabolic (heel-stick) screening panel for **[STATE]**.

Postpartum and Discharge

- **Length of stay:** [LENGTH OF STAY]
- **Postpartum mood screening:** I consent to routine screening for perinatal mood and anxiety disorders and request referral information for postpartum follow-up.
- **Visitor policy:** [VISITOR PREFERENCES]
- **Pediatric follow-up:** To be identified prior to discharge.

Photography and Observers

- **Photography / video:** Yes No Staff Faces.
- **Students / residents / observers:** I do **not** consent to the presence of students, residents, or observers who are not part of my direct care team. Please identify any learner before entry and obtain my consent.
- **Recording of clinical staff:** I will not record individual clinicians without their consent. I will record my own labor and my baby in accordance with facility policy.

If baby requires NICU care: If baby must go to the NICU, one parent should accompany baby at all times where possible; I wish to provide colostrum/breast milk and practice skin-to-skin as soon as baby's condition allows.

Acknowledgments

I acknowledge that:

1. This birth plan represents my **preferences**, not a demand for particular medical care or a refusal of life-saving intervention in a genuine emergency.

2. I have discussed the material elements of this plan with my provider, **[OB MIDWIFE PRIMARY PROVIDER NAME]**.
3. I accept that the course of labor is unpredictable and that clinical necessity may require deviation from this plan.
4. Where my elections require signed refusal forms under facility policy or state law, I will execute those forms at admission.
5. This document is my current and considered plan as of ****, and supersedes any prior birth plan I have prepared.
6. Nothing in this document modifies any separately executed Advance Directive, Healthcare Power of Attorney, or specific-treatment refusal form, which remain in full force.

Signature

Birthing Parent

________________________________ PRINTED NAME

________________________________ SIGNATURE

________________________________ DATE

Copies provided to: [BIRTHING PARENT S FULL LEGAL NAME]; [OB MIDWIFE PRIMARY PROVIDER NAME]; [PLANNED BIRTH FACILITY LOCATION] admissions / labor & delivery chart; .

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