



Southern Maryland Women's Healthcare, P.A.

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Birth Plan of _____ **Due Date:** _____
Labor Companions: _____ **Pediatrician:** _____

Fill out this plan according to your own wishes. Keep in mind that you might not be able to follow every wish on this page depending on if complications arise during your labor. Share your plan with your support team, practitioner, and labor nurse.

Standard Midwife Care includes the following:

Labor- Dim Lighting, wear your own clothing

Mobility- patients maintain mobility, including walking and changing positions

Hydration and Nourishment- IV access/saline lock during labor, patients are allowed to eat light snacks and drink clear fluids whenever possible during labor

Monitoring- Intermittent monitoring

Augmentation (methods to speed up labor if labor slows down)- non medical (i.e. walking and using upright labor positions), bag of water breaks on own, received and IV of pitocin only after all other methods are tried, an only if medically necessary

Pushing- patient waits until she feels the urge to push or until baby descends, patient may use a variety of positions while pushing, natural tearing instead of episiotomy, avoid forceps and/or vacuum extraction unless absolutely necessary, midwife hands baby directly to mom if there are no complications

Birth and Baby Care- skin to skin immediately after birth, breastfeeding as soon as possible, delayed cord clamping

In case of cesarean- mom and baby are not separated unless medically necessary, skin to skin as soon as possible

Post delivery- pitocin given to patient after delivery of the baby to reduce the risk of post partum hemorrhage

Labor and Delivery Options:

Pain Relief- Medical Option

- ☐ Stadol
- ☐ Epidural anesthesia
- ☐ I prefer that pain medication only be offered to me at my request

Pushing

- ☐ I would like a mirror placed at the foot of the bed so I can watch my baby's birth
- ☐ I would like to be directed as to when to push
- ☐ I would like to touch my baby's head as it crowns

Birth and Baby Care

- ☐ I would like the following test/shots/procedures:
 - ☐ Vitamin K
 - ☐ Erythromycin eye ointment
 - ☐ Hepatitis B Vaccine
- ☐ I would like the Vitamin K and eye ointment to be delayed until after the first breastfeed
- ☐ I am breastfeeding exclusively
 - ☐ I do not want my baby to be given formula
 - ☐ I do not want my baby to be given pacifiers
 - ☐ I do not want my baby to be given bottles
- ☐ I plan to formula feed only
- ☐ I prefer a combination of breastfeeding and formula feeding
- ☐ If I have a boy, I prefer to have him circumcised
 - ☐ My baby boy will be circumcised by his pediatrician
- ☐ I do not want my baby boy circumcised

