

BIRTH PREFERENCES FOR OBSTETRIC PATIENTS



USF Health
Morsani College of Medicine

Congratulations on your upcoming delivery! A birth plan is a document that lets your health care team know your preferences for labor and delivery. Please review and discuss your birth plan with your health care provider to ensure that everyone is aware of your wishes. Please know that your birth plan is important to our team. If there are safety concerns during your stay, your health care team will keep the health and safety of both you and your baby top priority to guide any necessary changes.

PERSONAL INFORMATION

Name you prefer to be called: _____

Preferred pronoun(s): _____

Support person's name: _____

LABOR PREFERENCES

Support persons present (three visitors allowed, but they can rotate throughout your stay):

☐ Partner's name: _____

☐ Doula's name: _____

☐ Family member(s); specify name and relationship:

☐ Friend(s); specify name and relationship:

Environment

We strive for dimmed lighting with minimal interruptions whenever possible. We welcome music during your stay, but please bring your own playlist. If your delivery is low risk, we work to have a quiet delivery to allow you to hear your baby's first breath.

Additional requests: _____

Pain relief

- | | |
|--|---|
| <input type="checkbox"/> Natural pain relief methods
(e.g., breathing, massage, etc.) | <input type="checkbox"/> Nitrous oxide |
| <input type="checkbox"/> Epidural | <input type="checkbox"/> IV pain medication |
| | <input type="checkbox"/> Other: _____ |

LABOR & DELIVERY PREFERENCES

Monitoring your baby's heart rate

This monitoring will be based on keeping you and your baby safe. Your health care team will work to keep you fully informed on safe alternatives, depending on your personal medical history and the medication being given during your delivery.

Options for low-risk delivery

- ☐ Intermittent fetal monitoring
- ☐ Continuous fetal monitoring
- ☐ Mobility
- ☐ Freedom to move around
- ☐ Use of birthing ball
- ☐ Use of birthing ball stool

Hydration

- ☐ Clear fluids
- ☐ Ice chips
- ☐ IV fluids only if necessary
- ☐ Food, if able

Interventions

- Induction/augmentation:
- ☐ Only if medically necessary
 - ☐ Open to discussion

Episiotomy: It is not our standard practice to perform episiotomy, and it would be done only in an urgent situation and following clear consent being provided. We follow the American College of Obstetricians and Gynecologists, where episiotomy is done only in situations when fetal complications require urgent delivery for fetal distress.

Avoid if possible: _____

This birth plan is designed to help communicate your wishes and preferences for labor and delivery. Please remember that the safety of you and your baby is the top priority, and flexibility may be necessary depending on the circumstances.

We look forward to supporting you in this special moment. If you have any questions or need further assistance, please contact us.

This template should be customizable to suit your individual patient needs and preferences.



**WOMEN'S
INSTITUTE**

DELIVERY PREFERENCES

Positions

- ☐ Upright
- ☐ Squatting
- ☐ On hands and knees
- ☐ Side-lying

Pushing

- ☐ Spontaneous pushing
- ☐ Directed pushing

Cord cutting

Name of person you would like to cut the cord:

- ☐ Delayed cord clamping greater than 30 seconds (it is our routine practice)

Cesarean section

- ☐ Partner present
- ☐ Clear drape to view delivery
- ☐ Skin-to-skin in the operating room, if possible

EMERGENCY SITUATIONS

If you need to undergo an emergency cesarean, we work to use your existing epidural, or spinal anesthesia. In the rare event when general anesthesia is necessary, for your patient safety, only TGH surgical team members will be in the operating room.

AFTER DELIVERY

Immediate care

- ☐ Immediate skin-to-skin contact
- ☐ Delay routine newborn procedures

Breastfeeding

- ☐ Initiate breastfeeding as soon as possible
- ☐ Lactation consultant present, if needed

Newborn procedures

- ☐ Delay first bath
- ☐ Vitamin K injection
- ☐ Hepatitis B vaccine
- ☐ Eye ointment

FINAL NOTES

Signature:

Patient: _____ Date: _____