BIRTH PLAN

Clark Memorial Hospital

A Norton and LifePoint Partnership

Our birth plan is intended to express preferences and desires for your birth experience, and our purpose is to assist you in delivering a healthy newborn. This plan may be altered due to changes in your condition or the condition of your baby. If changes occur, we will ALWAYS discuss options with you so that you are able to make informed decisions about the care you and your baby are receiving.

For information about Childbirth Preparation Classes or to register call 812-283-2405.

If you are interested in touring our Family Birth Place, please call 812-283-2050 to schedule a tour.

YOUR NAME _____ EMAIL _____

NAME OF YOUR MIDWIFE & OBSTETRICIAN _____ DUE DATE _____

ENVIRONMENT *(Check all that apply)*

☐ Dim lights ☐ Music ☐ TV ☐ Wear my own clothes ☐ Other (Please describe) _____

REQUESTS FOR LABOR

Physical ability to *(Check all that apply)*

☐ Be mobile ☐ Walk ☐ Rock ☐ Squat ☐ Try multiple positions ☐ Use tub/shower ☐ Use Birthing ball ☐ Use Peanut ball

Various Options *(Check all that apply)*

☐ Heparin Lock only (no running IVs unless medically necessary)

☐ Intermittent Monitoring (ACOG Standards)

☐ Pain medication offered if I'm uncomfortable

☐ Epidural as soon as possible

☐ Spontaneous Bearing Down

☐ Prefer no episiotomy

☐ To begin labor on my own

☐ Have my water broken

☐ Nipple stimulation

☐ Continuous Monitoring with telemetry capabilities

☐ Please do not offer me pain control options, I will ask if I need it

☐ Please do not offer me an epidural

☐ Directed Pushing ☐ Offer pushing position options

☐ Prefer to tear instead of having an episiotomy

☐ Pitocin

☐ Rice sock for comfort (bring your own)

In the event that a Cesarean delivery should occur, I would like: ☐ Clear C-section drape
☐ Kangaroo Care in the operating room

Visitors I would like present during labor and delivery:

_____

_____

Other *(Please describe)*

_____

_____

BABY CARE

☐ Would like to have my partner cut the cord

☐ No pacifier or artificial nipples unless medically indicated

☐ Delay cord clamp

☐ May use pacifier (bring your own)

☐ Breastfeed ☐ Bottle feed ☐ Combination of both

☐ Would like my partner to remain with my baby when my baby is not with me

I understand that this plan may be altered due to changes in my condition or the condition of my baby.

I agree to have my MD/Midwife and Pediatrician sign my birth plan to indicate their agreement with my plan.

SIGNATURE OF MOTHER _____ SIGNATURE OF FATHER _____

SIGNATURE OF MOTHER'S MD/MIDWIFE _____ SIGNATURE OF PEDIATRICIAN *(not required)* _____