

This document is intended as a communication tool between patient and healthcare team intended to provide the healthcare team with the patient's preferences. It is important to remember that one plan does not fit all and each woman's labor and birth is unique. There may be some circumstances, for the safety and well-being of mother and baby, which would prohibit the selected birth preferences from being followed. As such, use of the preferences outlined below are at the discretion of the healthcare team, after evaluation of the circumstances of each individual labor and birth.

**This document is provided to you by Cleveland Clinic Martin Health working in partnership with your OB Practice Physicians and Midwives**

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Mother's Name

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Partner's Name

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Due Date

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Hospital Name

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OB Physician Group Name

## EARLY/ FIRST STAGE LABOR

### Environment

- |  |                                       |   |
|--|---------------------------------------|---|
| <input type="checkbox"/> Aromatherapy      | <input type="checkbox"/> Low lighting | <input type="checkbox"/> Battery operated candles     |
| <input type="checkbox"/> Quiet room        | <input type="checkbox"/> Music        | <input type="checkbox"/> My own playlist on my device |
| <input type="checkbox"/> Wear own clothing |                                       |   |

### Mobility

- |  |  |
|--|--|
| <input type="checkbox"/> Stand Up      | <input type="checkbox"/> In the shower   |
| <input type="checkbox"/> Lying down    | <input type="checkbox"/> In the bath tub |
| <input type="checkbox"/> Rocking chair | <input type="checkbox"/> Walking around  |

### Hydration

- ☐ No restrictions unless medically indicated
- ☐ Clear fluids
- ☐ Ice chips

### External Fetal Monitoring

- ☐ Intermittent
- ☐ Continuous
- ☐ Wireless

### Pain Relief Offer

- ☐ Do not offer, I will ask if I desire it
- ☐ Offer if I appear uncomfortable
- ☐ Offer as soon as possible

### Pain Relief Options

- |   |  |
|---|--|
| <input type="checkbox"/> Relaxation breathing | <input type="checkbox"/> Massage       |
| <input type="checkbox"/> Hot or cold compress | <input type="checkbox"/> Birthing ball |
| <input type="checkbox"/> Positioning          | <input type="checkbox"/> Peanut ball   |
| <input type="checkbox"/> Water therapy        | <input type="checkbox"/> Epidural      |
| (bath, whirlpool, shower)                     | <input type="checkbox"/> Nitrous Oxide |
| <input type="checkbox"/> IV Pain medication   |  |

### Labor Induction/Augmentation

- ☐ Performed only if medically indicated
- ☐ Cervical ripening agent (s)
- ☐ Pitocin
- ☐ Rupture of amniotic sac
- ☐ I prefer my amniotic sac be allowed to rupture on its own

## SECOND STAGE LABOR

### Pain Relief Options

- |   |  |
|---|--|
| <input type="checkbox"/> Relaxation breathing | <input type="checkbox"/> Massage       |
| <input type="checkbox"/> Hot or cold compress | <input type="checkbox"/> Birthing ball |
| <input type="checkbox"/> Positioning          | <input type="checkbox"/> Peanut ball   |
| <input type="checkbox"/> Water therapy        | <input type="checkbox"/> Epidural      |
| (bath, whirlpool, shower)                     | <input type="checkbox"/> Nitrous Oxide |
| <input type="checkbox"/> IV Pain medication   |  |

### Labor Induction/Augmentation

- ☐ Performed only if medically indicated
- ☐ Cervical ripening agent (s)
- ☐ Pitocin
- ☐ Rupture of amniotic sac
- ☐ I prefer my amniotic sac be allowed to rupture on its own

## THIRD STAGE LABOR/ DELIVERY OF PLACENTA

### Immediately Following Delivery

- ☐ Place baby on my chest – SKIN TO SKIN
- ☐ Partner/Coach to cut the cord
- ☐ Partner/Coach does NOT want to cut the cord
- ☐ I would like to cut the cord
- ☐ Delay cord clamping
- ☐ To bank the cord blood

### Placenta

- ☐ To deliver placenta spontaneously
- ☐ To see the placenta before it is discarded
- ☐ I would like to take placenta home as condition allows. I will provide cooler for transport.

## CESAREAN SECTION

### If a C-section Is Necessary, I Would Like

- |  |  |
|--|--|
| <input type="checkbox"/> Partner/Coach present as condition allows | <input type="checkbox"/> Pictures  |
| <input type="checkbox"/> to stay conscious as condition allows     | <input type="checkbox"/> Immediate SKIN to SKIN                          |
| <input type="checkbox"/> My hands left free so I can touch my baby | <input type="checkbox"/> Breastfeed in OR as Mom & Baby condition allows |
| <input type="checkbox"/> Please use a clear drape                  |  |
| <input type="checkbox"/> Screen lowered at delivery                |  |

## SPECIAL CARE NEWBORN

### In the Event My baby Requires Special Care

- ☐ I would like to breastfeed
- ☐ If unable to breastfeed due to baby's medical condition, I would like to pump
- ☐ To hold my baby whenever possible

## THE MAGICAL HOUR

### Baby's First Hour of Life

- ☐ I would like to keep my baby SKIN TO SKIN
- ☐ I choose to breastfeed exclusively and would like to do so as soon as possible within the 1st hour
- ☐ I would like to meet with a lactation consultant as soon as possible
- ☐ I choose to formula feed
- ☐ I do not want baby to be given a pacifier

## BABY CARE

### In the Event My baby Requires Special Care

- |  |   |
|--|---|
| <input type="checkbox"/> Medical exam performed in my presence   | <input type="checkbox"/> First bath given in my partner's presence                        |
| <input type="checkbox"/> First bath given in my presence   | <input type="checkbox"/> First bath given by my partner                                   |
| <input type="checkbox"/> First bath given by me  | <input type="checkbox"/> I do NOT want my baby circumcised                                |
| <input type="checkbox"/> I want my baby circumcised by OB Physician<br>(To be arranged at OB office prior to delivery) | <input type="checkbox"/> I want my baby circumcised by my Pediatrician<br>at their office |