



BIRTH PLAN

Dr. Ford | Dr. Fernando | Dr. Keuchel | Dr. Miles | Dr. Smith | Sarah Trost

PATIENT INFORMATION

Name: _____ DOB: ____/____/____ Physician: _____
Baby Name: _____ EDD: ____/____/____ Pediatrician: _____

GBS: Positive or Negative Blood Type: A B AB O RH: Positive or Negative

Other medical Issues: _____

Previous Delivery Experiences: _____

LABOR

Who do you want in the room? Name / Relationship.

Atmosphere

Lights? _____

Music? _____

Other? _____

Nutrition

Clear liquids	Clear soda	Popsicles
Broth	Jello	Water

IV: Continuous or Saline lock

Pain Relief

Shower Breathing/Relaxation

Distraction Pain medications

Massage (family provided) Epidural

Meditation Other: _____

DELIVERY

Who do you want in the room? Name/ Relationship.

Positioning? _____

Mirror? Yes or No

Who is cutting the cord? _____

Feeding: Breast or Bottle

POST PARTUM

Who do you want in the room? Name/ Relationship.

Pain Relief/Meds: _____

Wear your own clothes? Yes or No

Is there any additional information that you would like your OB/GYN to know?

This form is designed to help you communicate your desires for labor and delivery to your OB/GYN. This form is designed to provide general guidelines during your stay at Stillwater Medical Center. Elements of this form are subject to change and should not be considered binding.