STILLWATER Women's CLINIC

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 known?

_____

_____

_____

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.