

# My Birth Preferences

Mother's Name: \_\_\_\_\_

Provider: \_\_\_\_\_

Birth Place: \_\_\_\_\_

Estimated Due Date: \_\_\_\_\_

My Support Team:

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

## My Birth Environment

### Lighting

- Dim
- Bright

### Aromatherapy

- No
- Yes

If yes, what scent(s)?

\_\_\_\_\_

\_\_\_\_\_

### Sound

- Quiet
- Music

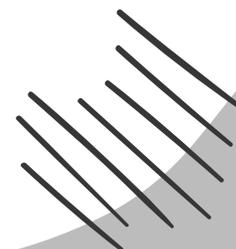
If music, what music?

\_\_\_\_\_

\_\_\_\_\_

## My Preferred Pain Relief

- Unmedicated
- Epidural
- Nitrous Oxide
- IV Pain medications
- Relaxation and breathing techniques
- Use of shower or tub



## My Birth Experience

### Cervical checks

- No preference
- Only when medically necessary

### Episiotomy

- Yes
- Allow me to tear naturally

### Fetal Monitoring

- Intermittent
- Continuous

### Birthing Tools

- Mirror
- Peanut ball
- Yoga ball
- Squat bar
- Other tools

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### Free to Move

- Yes
- No

### Pushing

- Coach me on when and how to push
- Do not coach me on pushing

### If I have a Cesarean Birth, I prefer...

- Dimmed lighting
- Quiet
- Immediate skin-to-skin
- Clear drape
- Other preferences:

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## After birth, I prefer...

### Baby's First Hours and Days

- Skin-to-skin contact immediately
- Baby will be rooming-in
- Bathe my baby at the hospital
- Ask me before a pacifier or formula is given to my baby
- My baby will be circumcised

### Umbilical Cord

- Delayed Cord Clamping
- Support person to cut the cord
- Cord blood banking:
  - Private bank
  - Public bank

### Feeding

- Breastfeeding
- Formula feeding
- Both

