BIRTH PREFERENCE

The Birth Preference form is designed to be used as a discussion tool with your midwife or medical practitioner. It should be brought with you to your 34 week medical appointment at Bendigo Health.

YOUR DETAILS

Name:_____ Contact Number:_____

Email Adress:_____

Support Person:_____ Contact Number:_____

Due Date:_____

Name of obstetritian/midwife:_____

Other birth-support:_____

Where do you want to give birth? ☐ At home ☐ Hospital ☐ Not sure

LABOUR AND BIRTH

Environment

☐ Dim Lights
☐ Quiet Music
☐ Aromatherapy oils
☐ Wear my own clothes

Other:_____

Mobility during labour ☐ would like to keep active during labour and birth (walking, fitball ect.)
☐ Mobility is not important to me

Relaxation and comfort during labour

☐ Massage ☐ Bath ☐ Fit ball
☐ Shower ☐ Bean bag ☐ Hot packs
☐ TENS ☐ Hypnotherapy

Other:_____

Position(s) for labour and birth

☐ Walking ☐ Standing ☐ Squatting
☐ Sitting ☐ Kneeling ☐ Lying Down
☐ Birth Stool Other:_____

Fetal Monitoring

☐ Continuous monitoring ☐ Intermittent monitoring

Vaginal/Cervix Examinations

☐ I would like minimal examinations

☐ I am happy for examinations as deemed necessary by medical or midwifery staff

Pain Relief

☐ Offer as soon as possible ☐ Offer if I appear uncomfortable

☐ Do not offer, I will ask if I want pain relief

Medical pain relief options

☐ I would like to try to manage without medical pain relief

☐ Nitrous Oxide Gas ☐ Morphine

☐ Epidural Other:_____

Breaking of my waters

☐ I prefer my amniotic sac be allowed to rupture on its own

☐ I have no preference if my membranes are artificially ruptured or allowed to rupture on their own

Episiotomy

☐ I would like an episiotomy to reduce the risk of tearing

☐ I do not want an episiotomy unless there is an emergency situation

Birth

☐ I would like to touch baby's head when close to giving birth

☐ I would like a mirror available to view pushing and birth

Immediately following delivery

tick as many as you wish

☐ I want baby placed on my chest immediately after birth

☐ Please delay cord clamping and cutting until pulsating ceases

☐ I would like my birth partner to cut the cord

☐ I would like to cut the cord

☐ Birth partner does not want to cut the cord

☐ I would like to hold the baby while the placenta is delivered

☐ I would like to discuss my options concerning drug administration to reduce the risks of haemorrhage after the birth of the baby.

☐ I would like the baby to be examined in my presence

☐ If the baby cannot be examined in my presence, I would like my birth partner to remain with the baby at all times

Assisted delivery

If additional medical assistance is required for the birth, I would prefer:

☐ Assisted delivery - vacuum ☐ Caesarean section ☐ Assisted delivery - forceps

Caesarean

In the event that a caesarean section is deemed necessary, I would like the following:

☐ Birth partner present
☐ Other support present
☐ Photos
☐ Screen lowered for birth
☐ I would like skin to skin contact or to breast feed as soon as possible in theatre
☐ I would like baby to remain with me in the theatre recovery area

Other:_____

BABY CARE

Feeding Baby

☐ I wish to breastfeed exclusively
☐ I wish to breastfeed, but formula supplementation is acceptable if medically indicated
☐ I wish to formula feed
☐ I do not want baby to be given a pacifier
☐ I would like to meet with a lactation consultant

Vitamin K - Hospital recommendation is for a single injection of Vitamin K soon after birth

☐ I would like my baby to have the single recommended injection of Vitamin K
☐ I would like my baby to have oral Vitamin K
☐ I do not want my baby to have Vitamin K

Hepatitis B - Hospital recommendation is for a single injection of Hepatitis B soon after birth

☐ I would like my baby to have the single recommended injection of Hepatitis B
☐ I would like my baby to have oral Hepatitis B
☐ I do not want my baby to have Vitamin K

Any special dietary requirements for the new Mum

_____

_____

Other special needs for new Mum and/or birth partner (language, religion, disability, etc.)

_____

_____

Length of stay in hospital

Length of stay recommended by the hospital is between 4 and 48hrs unless otherwise indicated.

Your Signature:_____ Date:_____

Healthcare Provider's Name:_____

Healthcare Provider's Signature:_____ Date:_____