Your Details

Name: ____________________________ Contact Number: ____________________________

Email Address: ____________________________

Birth Partner’s Name: ____________________________ Contact Number: ____________________________

Due Date: ____________________________

Name of obstetrician / midwife: ____________________________

Other birth-support (doula/other family): ____________________________

Where do you want to give birth?

- [ ] Hospital: ____________________________
- [ ] Birth Centre: ____________________________
- [ ] At home
- [ ] Not sure yet

Labour & Birth

Environment

- [ ] Dim lights
- [ ] Aromatherapy oils
- [ ] OK to have training medical staff observe labour & birth
- [ ] Quiet music
- [ ] Wear my own clothes
- [ ] Other: ____________________________

Mobility during labour

- [ ] I would like to keep active during labour if possible (walking, fitball, etc.)
- [ ] Mobility is not important to me

Relaxation and comfort during labour

- [ ] Massage
- [ ] Shower
- [ ] Bean bag
- [ ] Acupressure
- [ ] Bath
- [ ] Fit ball
- [ ] Hot towels
- [ ] Hypnotherapy
- [ ] Other: ____________________________

Do you want to use any special facilities?

- [ ] Birthing pool
- [ ] Other: ____________________________
Position(s) for labour & birth
Tick as many as you like - underline preferred birth position
☐ Walking ☐ Standing
☐ Squatting ☐ Sitting
☐ Kneeling ☐ Lying down
☐ Birth Stool ☐ Other ________

Foetal Monitoring
☐ Continuous monitoring (will mean limited mobility)
☐ Intermittent monitoring
☐ No monitoring - except in emergency situations

Vaginal / Cervix Examinations
☐ I would like minimal examinations
☐ I am happy for examinations as deemed necessary by medical staff
☐ No monitoring - except in emergency situations

Pain Relief
☐ Do not offer; I will ask if I want pain relief
☐ Offer if I appear uncomfortable
☐ Offer as soon as possible

Medical pain relief options
Number any acceptable options in order of preference
☐ I would like to try to manage without medical pain relief options
☐ Gas / Air ☐ Pethidine
☐ Epidural ☐ Other ________

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

Episiotomy
☐ I do not want an episiotomy unless there is an emergency situation
☐ I would like an episiotomy to reduce the risk of tearing

Delivery
☐ I would like to touch baby’s head when it crowns
☐ I would like a mirror available to view pushing/crowning/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 do not want an injection to assist with placenta delivery
☐ 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
☐ I want to donate cord blood to the public cord blood bank (if service is available)
☐ I want to bank cord blood privately
Assisted delivery
If additional medical assistance is required for the birth, I would prefer:
- Assisted delivery - forceps
- Assisted delivery - ventouse
- Caesarean section

Caesarean
In the event that a cesarean section is deemed necessary, I would like the following:
- Birth partner present
- Photos / video
- I would like the procedure described as it is happening
- Other support present
- Screen lowered at delivery
- Other: ____________________________

Baby Care

Feeding Baby
- I wish to breastfeed exclusively
- I wish to breastfeed, but formula supplementation is acceptable
- 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
- I would like my baby to have the single 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
- I would like my baby to be vaccinated with Hepatitis B vaccine before discharge

Any Special Dietary Requirements for the new Mum

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

Length of stay in hospital
- I would like to have as short a stay as possible in hospital
- I would like to stay in hospital for 1-2 days after the birth
- I would like to stay in hospital for more than 2 days after the birth

In the event that baby requires special care due to trauma or illness
- I would like to breastfeed/pump breast milk
- Birth partner will accompany baby if transferred to another hospital
- I would like to be transferred to baby's hospital

Your Signature: ____________________________ Date: ____________________________

Healthcare Provider’s Name: ____________________________
Healthcare Provider’s Signature: ____________________________ Date: ____________________________