Mount Sinai Hospital
Sinai Health System
Joseph & Wolf Lebovic
Health Complex

600 University Avenue
Toronto, Ontario, Canada M5G 1X5

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Planning your Birth Experience

Clearly imprint patient identification card

The health care providers at Mount Sinai Hospital including obstetricians, family doctors, midwives and nurses believe that birth is a normal physiologic event, which can be life changing . We believe that participating in this event with you is important to us throughout your whole hospital stay. We want to learn more about you and have a way for you to communicate your hopes and wishes to us regarding your labour, birth and care throughout. Planning your birth experience is really about determining your wishes. Circumstances during your labour and birth can sometimes change the plan you made in your pregnancy. This form is intended to begin your thinking about your wishes for this experience, and it is intended to guide your discussion with your care providers.
We hope that you will take the time to fill this out and talk it over with your health care provider in pregnancy. Then please bring it with you when you are in labour so it can be discussed with your care providers during your hospital stay and become part of your chart.

Getting to Know Me:

My due date is: ____________________ (YYYY MM DD)

I am expecting ☐ multiples ☐ twins ☐ boy ☐ girl ☐ a surprise?

Baby's**(ies)** name**(s)** is**/are** already decided ____________

The doctor who cared for me in my pregnancy ________________________________

The following people will be with me:

During labour:

Partner: ____________________ (name)

Doula ____________________ (name)

Friend/Other __________________ (name/relationship)

During the birth:

Partner: ____________________ (name)

Doula: ____________________ (name)

Friend/Other: __________________ (name/relationship)

They will support me by: ________________________________

If I have a Cesarean Birth ____________________ (name) will accompany me into the Operating room.

Pain Management preferences:

☐ I want a medication-free birth

☐ I want a medication-free birth if my labour goes well, but will consider pain medications if things do not go as expected

☐ I want medication but I would like to go as long as possible without it

☐ I want medication as soon as possible

Options I hope to use in labour include:

☐ tub bath/shower
☐ hot/cold compresses
☐ birthing ball/ labour stool
☐ different positions, eg. Side lying
☐ walking
☐ listen to my own music
☐ epidural
☐ use of the squatting bar
☐ pillows (may bring own)
☐ Nitronox (laughing gas)
☐ Breathing and relaxation

Other options ________________________________

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Other things I would like you to know about me/us (important issues, fears, concerns, previous experiences):

____

____

After the baby(s) is born, I would like to:

☐ have skin to skin care for a least one hour after birth

☐ have ____________________ (name) hold my baby(s) skin to skin if I am not able to do this myself

☐ have ____________________ (name) cut the cord

☐ have ____________________ (name) take pictures/video

☐ have ____________________ (name) put on the first diaper

☐ have delayed cord clamping if possible

If my baby(s) needed special care, I would like to have ____________________ (name) be offered the opportunity to go with my baby(s) as soon as it is possible.

☐ I have arranged for stem cell collection and I will bring my collection kit and the completed paperwork

Other things that are important to me in the care of my baby(s) ____________________

____

____

____

The physician who will care for my baby is ________________________________

My plan for feeding my baby is:

☐ breastfeeding ☐ formula feeding ☐ pumping and feeding pumped breastmilk by bottle

☐ I had problems with breastfeeding a previous baby and would appreciate extra help this time

During my stay in the mother/baby unit, I would like to:

☐ have ____________________ stay with me in my room, for support

☐ be present for any tests or examinations of my baby, eg. Newborn screening

☐ give the baby's first bath with help

The following people will be helping me at home: ________________________________

____

Date (YYYY MM DD)	Time (HH:MM)	Mother's Print Name	Mother's Signature
Date (YYYY MM DD)	Time (HH:MM)	Support Person Print Name	Support Person Signature

This plan has been reviewed with the patient and family at transfer from intrapartum to postpartum

Date	Time	Print Name of Intrapartum Nurse	Signatures
(YYYY MM DD)	(HH:MM)		, R.N.
		Print Name of Post Partum Nurse	
(YYYY MM DD)	(HH:MM)		, R.N.

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