BIRTH PLAN CHECKLIST

MOTHER INFORMATION

Name:_____

Healthcare Provider: _____

Due Date: _____

COMPANIONSHIP

Name: _____

Phone #: _____

LABOR

☐ Music

☐ Home objects (i.e. blankets, clothing, etc.)

☐ Quiet

☐ Dim Lights

☐ Photos and/or video

MOBILITY

☐ Complete mobility: adjusting position, walking

☐ Partial mobility: bathroom use, moving in bed

☐ No mobility preferences

PAIN RELIEF

Medical

☐ Epidural anesthesia

☐ Analgesic

☐ Only upon request

Nonmedical

☐ Fitness ball

☐ Breathing techniques

☐ Massage

NOURISHMENT

☐ Fluids & light snacks at all times

☐ Constant monitoring