Upland Hills® Health Birth Center

Pre-Delivery Conference
Birth Plan

Name: _____ Phone: _____

Address: _____

Support Person: _____ Phone: _____ Relationship: _____

How many people do you plan to have at your delivery? _____

Are you married or were you married during this pregnancy? ☐ Yes ☐ No

How tall are you? _____ What was your pre-pregnancy weight? _____

Please list any medical history.

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Do you have a history of Group B Strep with your current or past pregnancies? ☐ Yes ☐ No

Do you have a history of or currently have a multi drug resistant organism (ex: MRSA or VRE)? ☐ Yes ☐ No

Do you have any allergies? ☐ Yes ☐ No If so, please list allergies and what are your reactions? _____

_____

What is your preferred pharmacy? _____

Please list medications you are taking and the dosage (including vitamins and supplements):

_____ _____ _____

_____ _____ _____

Do you use any self-administered medications such as eye drops, inhalers, or injectable blood thinners/anticoagulants (Lovenox, Heprin, etc.)? ☐ Yes ☐ No Please list _____

Please list your surgical history:

_____ _____ _____

_____ _____ _____

Do you currently smoke? ☐ Yes ☐ No Have you smoked at all during this pregnancy? ☐ Yes ☐ No
If so, how many packs a day? _____

Do you use E cigarettes? ☐ Yes ☐ No Do you use smokeless tobacco? ☐ Yes ☐ No

If yes to any of these questions, would you like information on quitting? ☐ Yes ☐ No

Do you need a nicotine patch during your hospital stay? *(We do not allow patient to leave the premise to smoke)* ☐ Yes ☐ No

Do you currently use alcohol or did you at any time during your pregnancy? ☐ Yes ☐ No

Do you or have you used any type of illegal drugs (cocaine, heroin, Marijuana, or methamphetamines) before or during your pregnancy? ☐ Yes ☐ No

Do you have anything implanted in your body? ☐ Yes ☐ No

Do you have any piercings? ☐ Yes ☐ No If yes please state where: _____

_____

Do you have any tattoos? ☐ Yes ☐ No If yes please state where: _____

_____

Have you received your Flu shot (if between Sept-March)? ☐ Yes ☐ No
If not, would you like one prior to discharge? ☐ Yes ☐ No

Any contraindications to flu shot (allergy to thimerosal or flu vaccine, history of Guillain-Barre Syndrome)? ☐ Yes ☐ No

History of gastric altering surgery? ☐ Yes ☐ No Have you lost weight without trying? ☐ Yes ☐ No

Have you been eating poorly because of decreased appetite? ☐ Yes ☐ No

Have you ever been diagnosed with sleep apnea? ☐ Yes ☐ No

Any issues with seeing, hearing, mobility, doing activities of daily living, concentrating/remembering/making decisions?
☐ Yes ☐ No

Additional Comments _____

_____

Pregnancy overview/history

Number of babies this pregnancy? _____ If twins: (please check one) ☐ Mono-Mono ☐ Mono-Di ☐ Di-Di

Planned Delivery Method?
Please check one: ☐ Vaginal ☐ C-Section ☐ Repeat C-section ☐ TOLAC (Trial of Labor After a Cesarean)

Estimated Delivery Date: _____ 1st day of your last menstrual period _____

What number of pregnancy is this for you? _____ How many live births have you had?_____

Any other pregnancy outcomes (miscarriage, stillbirth, abortion)? ☐ Yes ☐ No
If yes: Dates and Type of other outcomes: _____

Were there any complications with your previous deliveries? ☐ Yes ☐ No If yes please explain: _____

_____

Have you ever had a uterine incision? ☐ Yes ☐ No explain: _____

_____

Are you on Anticoagulant Therapy or have a known bleeding disorder? (aspirin, lovenox, heparin) ☐ Yes ☐ No
If Yes, what medication: _____

Did you have a postpartum hemorrhage (extra heavy bleeding after delivery)? (did you receive blood products, extra medications to help stop or slow bleeding) ☐ Yes ☐ No
If yes, please explain: _____

_____

In our previous deliveries, did your provider have to use a vacuum or forceps during your delivery? Yes/No
If yes, Please explain: _____

_____

Did you have any vaginal tearing or need stitches with your delivieries? ☐ Yes ☐ No
If yes, please explain: _____

_____

Have you been diagnosed with Pre-Eclampsia or Gestational Hypertension with this pregnancy or in the past? ☐ Yes ☐ No

Have you been diagnosed with Diabetes or Gestational Diabetes with this pregnancy or in the past? ☐ Yes ☐ No
If yes, are you using diet or medication to control diabetes at this time? _____

_____

Have you had any complications with this pregnancy? ☐ Yes ☐ No
If yes please explain: _____

_____

Additional Information: _____

_____

Are you receiving prenatal care with an Upland Hills Health provider? ☐ Yes ☐ No

Have you recieved any additional care with this pregancy from another facility or provider? ☐ Yes ☐ No
If yes, where, and who did you see? _____

Who is your current OB provider: _____

Who is going to be your baby's physician: _____
(We would like you to choose a baby doctor prior to delivery–Please ask if you have any questions)
(If baby's doctor is going to be at a different facility, the on-call doctor will see your baby at the hospital.)

Did you take a Childbirth Class? ☐ Yes ☐ No

Did you take a Breastfeeding Class? ☐ Yes ☐ No

Please list things you would like to have during your labor:

☐ birthing/peanut balls
☐ shower
☐ tub
☐ lighting
☐ music (please bring your own)
☐ fetal monitoring (minimal, moderate, continuous- if medically able to accommodate)
☐ squat bar
☐ position changes
☐ walking
☐ mirror during delivery
☐ other: _____

_____

Pain Management Preferences: Please check if interested, may check multiple boxes.

☐ Natural- (ball, shower, tub, massage, etc)
☐ Nitrous Oxide- (inhalation gas)
☐ IV Narcotic (Fentanyl, etc.)
☐ Epidural

Any comments about preferences related to pain management: _____

_____

If you are planning to have a C-section, would you like to have a clear drape if possible, during your c-section? ☐ Yes ☐ No

Will you accept all blood products if needed emergently? ☐ Yes ☐ No

Are you planning on collecting cord blood? ☐ Yes ☐ No *(Patients will have to purchase their own kit well in advance. Please bring it to your prenatal appointment so your doctor can look at the kit.)*

Are you planning on giving the baby up for adoption? ☐ Yes ☐ No

Are you planning on having a tubal ligation (your tubes tied to prevent future pregnancies) after the baby is born? ☐ Yes ☐ No
If yes, have you signed a consent at a clinic appointment with your provider? ☐ Yes ☐ No

Baby

Do you know the gender of your baby? ☐ Boy ☐ Girl ☐ Surprise

If you have a boy, would you like him to be circumcised? ☐ Yes ☐ No

Planned last name of baby? _____

Feeding intentions: ☐ Breast ☐ Bottle (Formula) ☐ Combination ☐ Pumping and Feeding

Do you have a breast pump? ☐ Yes ☐ No

Are you ok with baby getting Erythromycin ointment in their eyes? ☐ Yes ☐ No

Are you ok with baby getting vitamin K injection in their thigh? ☐ Yes ☐ No

Would you like your baby to receive a Hepatitis B vaccine? ☐ Yes ☐ No
(We will have you sign a consent for either acceptance or refusal of vaccination)

Do you want delayed newborn bathing? ☐ Yes ☐ No What are your preferences? _____
_____

When your baby is born, would you like the baby to be placed on your chest? ☐ Yes ☐ No
Or if in the OR would like to have baby skin to skin as soon as possible if you and your baby are both medically stable?
☐ Yes ☐ No

Do you want your support person to announce the baby's gender? ☐ Yes ☐ No

Do you want your support person to cut the baby's cord? ☐ Yes ☐ No

Do you want delayed cord clamping?
(Our providers typically delay for one minute as long as the baby and mother are doing well) ☐ Yes ☐ No

Are you planning to keep your placenta? ☐ Yes ☐ No

Do you want baby to have a pacifier? ☐ Yes ☐ No

Are you ok with baby getting sucrose (sugar water) for procedures or to help calm baby (not to replace a feeding) ☐ Yes ☐ No

Emotional/Social/Financial Wellbeing

1. In the past 30 days, have you wished you were dead or wished you could go to sleep and not wake up? ☐ Yes ☐ No
2. In the past 30 days, have you had any thoughts about taking your own life? ☐ Yes ☐ No
3. In your lifetime, have you ever done anything, started to do anything, or prepared to do anything to end your life? ☐ Yes ☐ No
4. In the past 2 weeks have you felt down, depressed or helpless? ☐ Yes ☐ No
5. In the past 2 weeks have you had little interest or loss of interest in … (interest in life, etc.)?
   Comments: _____
   _____
6. Do you feel safe at home? ☐ Yes ☐ No
7. Have you ever been hit, hurt or threatened? ☐ Yes ☐ No ☐ Yes, I have in the past but have good support now.
8. Within the past year, have you been afraid of your partner or ex-partner? ☐ Yes ☐ No
9. Have you ever been a victim of violence? ☐ Yes ☐ No If so what form?
10. How hard is it for you to pay for the basics like food, housing, medical care, and heating?
    check one: ☐ Very Hard ☐ Hard ☐ Somewhat Hard ☐ Not very hard ☐ Not hard at all ☐ Patient refused
11. In the last 12 months, was there a time when you were not able to pay the mortgage or rent on time?
    ☐ Yes ☐ No ☐ Prefer not to answer.
12. In the last 12 months, how many places have you lived? _____
13. In the last 12 months, was there a time when you did not have a steady place to sleep or slept in a shelter?
    ☐ Yes ☐ No ☐ Prefer not to answer.
14. In the past 12 months, has lack of transportation kept you from medical appointments or getting medications?
    ☐ Yes ☐ No ☐ Prefer not to answer.

15. In the past 12 months, has lack of transportation kept you from meetings, work, or from getting things needed for daily living?
☐ Yes ☐ No ☐ Prefer not to answer.

16. Within the past 12 months, have you worried that your food would run out before you got the money to buy more.
☐ never true ☐ sometimes true ☐ often true ☐ Prefer not to answer.

17. Within the past 12 months, the food you bought just didn't last and you didn't have money to get more?
☐ never true ☐ sometimes true ☐ often true ☐ Prefer not to answer.

18. Do you feel stress, tense, restless, nervous, or anxious, or unable to sleep at night because your mind is troubled all the time?
☐ Yes ☐ No

19. Are you planning on bringing weapons to the hospital? ☐ Yes ☐ No

20. Do you have a history of physical violence or aggression toward health care workers? ☐ Yes ☐ No

21. Has anyone every threatened that they are going to hurt you or take your baby? ☐ Yes ☐ No

Fall Risk

1. Have you fallen: (please check one)
☐ no falls ☐ within the last year ☐ within the last 6 months ☐ within the last month ☐ during my last hospitalization

2. Any mobility limitations? ☐ Yes ☐ No_____ Do you use an assistive device? ☐ Yes ☐ No _____

3. Do you take any medications that would make you fall? (ex: narcotics or diuretic medications) _____

4. Any current issues with nausea, vomiting or diarrhea? ☐ Yes ☐ No _____

5. Any communication or sensory issues (Do you wear glasses or contacts? ☐ Yes ☐ No _____

Health Care Decision maker

Are you able to make informed decisions regarding your health and treatment? ☐ Yes ☐ No

Do you have current documentation for a healthcare decision maker? ☐ Yes ☐ No

Do you have an advanced directive, or a living will? ☐ Yes ☐ No
Would you like assistance with completing one? Or information about advanced directives? ☐ Yes ☐ No

Would you like any spiritual, emotional, or cultural support during your stay? ☐ Yes ☐ No

Did you receive WIC (Women, Infants and Children program) throughout your pregnancy? ☐ Yes ☐ No

Patient

What is your highest level of education? _____

Any barriers with learning? ☐ Yes ☐ No _____

How do you prefer to learn? ☐ reading ☐ listening ☐ demonstration or pictures and video ☐ all the above
please check at least one or multiple

Co-Learner

What is your highest level of education?_____

Any barriers with learning? ☐ Yes ☐ No _____

How do you prefer to learn? ☐ reading ☐ listening ☐ demonstration or pictures and video ☐ all the above
please check at least one or multiple

Please list any comments/ concerns/ or questions below: _____

_____

_____

_____

Signed: Upload Signature Here Date: _____

Save form and send to the Birth Center Staff at: uhhobpdc@uplandhillshealth.org. Or print and give to your Doctor.