

Advanced Care Birth Plan

At our hospital, you and your baby are our top priorities. Our goal is to provide the very best care, while honoring your preferences for your birth experience. This birth plan was designed to meet the unique needs of families whose baby is diagnosed before birth with a life-limiting condition.

We understand that making decisions about your birth plan under these difficult circumstances can be challenging. Please complete each section of this plan to the best of your ability. While some situations may develop that require changes, the plan will serve as a guide for your wishes during labor, delivery, postpartum care and neonatal care for your baby. It will help us ensure your hopes, goals and values are integrated in the plan of care, and that tender memories are created for the birth of your baby.

Birth plan for Baby _____ diagnosed with _____
(Baby's full name) (Baby's condition)

Mother's Full Name Father/Partner's Full Name

Name(s) and age(s) of sibling(s)

We had genetic testing during this pregnancy: **Yes** **No**

Genetic counseling was provided by _____
(Name of Genetic Counselor)

We have been assisted by _____ at _____ hospital.
(Name of physician)

We would like the following medical caregivers to be notified as soon as possible after our baby is born:

Name of Medical Caregiver Phone Number

Name of Medical Caregiver Phone Number

Labor and Delivery

- We have been informed that **there is / is not** a high risk for stillbirth. (Please circle one.)
- We **want / do not want** our baby's heartbeat to be monitored during labor. (Please circle one.)
- If our baby's heartbeat is monitored during labor, we prefer **continuous / periodic** monitoring. (Please circle one.)
- If there is a loss of a heartbeat prior to delivery, **we do / do not** wish to be informed. (Please circle one.)

- Preferences for my pain management and medications during labor and delivery include: **(Please check one.)**
 - A fast-acting, short-term narcotic, given by either IV or injection. (This may make you feel sleepy.)
 - Epidural anesthesia. An anesthesiologist provides epidural medication. (You will not be able to walk around.)
 - At this time, I prefer not to have pain medication, but will let the medical team know if this changes.
- If medically safe for me and my baby, during labor I would like to: **(Please check all that apply.)**
 - Walk around
 - Use the birthing ball/rocking chair
 - Use the tub/shower
 - Listen to music (brought from home)
 - Have ice chips/sips of water
 - Have the lights dimmed
 - Have ice pops or other clear liquids
 - Other _____
- We have discussed the issue of C-section with:

| Name of Doctor | Affiliation | Phone Number | Date |
|----------------|-------------|--------------|------|
| | | | |

We are aware that there are greater risks to the mother associated with a C-section delivery when compared to a vaginal delivery. We know that a C-section may be necessary if an unexpected obstetrical issue arises that puts health in danger. We know that a C-section is not a guarantee of a live birth.

- We **want / do not want** a C-section for problems seen during fetal monitoring. **(Please circle one.)**
- We would like _____ to cut the cord after delivery, if possible.
(Name)
- We request that our baby be handed to his/her mother or father immediately after delivery, if circumstances allow: **Yes No**
- For our baby's comfort, please postpone the following routine procedures: **(Please check all that apply.)**
 - Vitamin K injection (Helps with blood clotting.)
 - Hepatitis B injection (Protects against the hepatitis B virus.)
 - Antibiotic eye ointment (Prevents eye infections.)
- We request that, if possible, routine and necessary procedures be performed with our baby in our arms. **Yes No**
- We would like to have our baby in the room with us for all routine care. **Yes No**

Additional Testing

For the purpose of chromosome studies or other special testing to help determine a cause for our baby's condition, please collect: **(Please check one.)**

- Cord blood
- Other
- Nothing

Managing Our Baby's Medical Needs

We have been informed of the natural history of our baby's diagnosis and the prognosis associated with this condition.

- If our baby is stillborn, we would like him/her to stay with us in our room for as long as possible. **Yes No**
- If our baby is born alive: **(Please check one.)**
 - We wish to use all medical interventions available in order to prolong our baby's life.
- OR
- We wish to use all medical interventions except _____ in order to prolong our baby's life.
- OR
- We want no heroic measures, such as ventilation or resuscitation, to be initiated. We want our baby to receive medication to promote comfort, but not to extend life. (Comfort care includes keeping our baby warm, pain medication, if necessary, feeding or other oral comfort measures.)

Feeding Our Baby

- | | Yes | No |
|------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| • We would like to attempt breast-feeding* | <input type="checkbox"/> | <input type="checkbox"/> |
| • Bottle-feeding of formula | <input type="checkbox"/> | <input type="checkbox"/> |
| • Bottle-feeding of breast milk | <input type="checkbox"/> | <input type="checkbox"/> |
| • Feeding via dropper, or feeding tube may be used if our baby cannot suck or swallow | <input type="checkbox"/> | <input type="checkbox"/> |

*Lactation consultants are available to discuss feeding and breast care, including how to dry up or donate breast milk.

Spiritual Support

We request that a ceremony (blessing, naming ceremony, baptism, etc.) be performed in accordance with our religious beliefs. **Yes** **No**

A representative from our faith community will be with us. _____
Name of Representative Phone Number

We would like assistance from the hospital chaplain

Our faith tradition is _____
(Please indicate your faith tradition, if known.)

• Special requests for spiritual support:

Family Time

(Please check all that apply.)

- We would like our designated family members to be present during the delivery, if possible.
- We would like family/friends to be able to join us in our room after delivery to spend time with us and our baby.
- We would like to bathe our baby.
- We would like to dress our baby.
- We would like help talking with our other child(ren).

• Special requests for sibling(s) and family members:

End of Life Care

Plans for our baby, should his/her death occur prior to hospital discharge, will include:

- | | Yes | No |
|---------------------------------------|--------------------------|--------------------------|
| • Autopsy | <input type="checkbox"/> | <input type="checkbox"/> |
| • Imaging autopsy* with external exam | <input type="checkbox"/> | <input type="checkbox"/> |

*Autopsy using X-ray, MRI or CT scan.

• We have made funeral and/or cremation arrangements with _____
Name of Funeral Home Phone Number

• Other end of life care requests for our baby:

Special Keepsakes

If possible, we would like to have the following keepsakes:

- | | | |
|-------------------------------------------|--------------------------------------------------|---------------------------------------------------------------|
| <input type="checkbox"/> Photos | <input type="checkbox"/> Plaster foot/hand molds | <input type="checkbox"/> ID band |
| <input type="checkbox"/> Foot/hand prints | <input type="checkbox"/> Lock of hair | <input type="checkbox"/> We do not wish to have any keepsakes |

• Other special keepsake requests:

Plans for Discharge

How your baby responds to labor and birth will be unique. Depending on the diagnosis and its effects, there is the potential your baby could live for a few minutes or hours, to a few days, or even longer. In the event your baby is discharged from the hospital, the healthcare team will assist you with identifying community-based palliative care support services.

Additional Requests for Our Birth Plan

Please use this space to list additional requests for your birth plan.

This birth plan was completed after discussion with the following medical providers: (Please print.)

| | | | |
|-------|-------|--------------|-------|
| _____ | _____ | _____ | _____ |
| Name | Title | Phone Number | Date |
| _____ | _____ | _____ | _____ |
| Name | Title | Phone Number | Date |
| _____ | _____ | _____ | _____ |
| Name | Title | Phone Number | Date |

Signatures of Parent (s): This birth plan serves as a guideline for our wishes for the delivery and care of our baby. We understand our plan may not be able to be followed in its entirety due to the unique needs of our baby, or to extenuating circumstances beyond our control.

Mother's Signature Date Father/Partner's Signature Date

Our hospital is committed to providing the very best care for you and your baby, while supporting your preferences for your birth experience. Please bring your completed and signed birth plan with you when you are admitted to the hospital. It will help us ensure your wishes are integrated in the plan of care.

If you have questions about the birth plan or your preferences change, please speak with a member of the healthcare team. We are here to help.