



My Birth Preferences

600 University Avenue
Toronto, Ontario, Canada M5G 1X5
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The health care providers at Mount Sinai Hospital believe that birth is a life changing event. Our team is here to provide excellent care and support to our patients with their unique birthing experiences and needs. To help us understand your birthing preferences, you can fill in the form below. Completing this form is optional. If you would prefer to tell us your preferences in person, we are happy to support what is best for you. **This form is meant to be a communication tool between you and your care team. It is not a “plan”, as we know that birth is unpredictable.** If you choose to fill in the form, please bring a copy with you when you come to the hospital to give birth.

Getting to know me:

My given name is: _____

I would like to be called: _____

My pronouns: _____ Language(s) I speak: _____

My partner/support person’s name is: _____

My partner/support person’s pronouns: _____ Language(s) they speak: _____

My due date is: _____ My planned induction or Caesarean birth is being planned for: _____
(YYYY MM DD) (YYYY MM DD)

I am expecting Single Twins Multiples

Baby’s(ies”) name(s) is/are already decided _____

If I have a Caesarean Birth _____ (Name/Pronoun) will accompany me into the Operating Room if medically possible.

Pain management preferences:

- I would prefer a medication-free birth
- I would prefer a medication-free birth if my labour goes well, but will consider pain medications if things do not go as expected
- I would prefer medication but I would like to go as long as possible without it
- I would prefer medication as soon as possible

Options I hope to use in labour include:

- | | | |
|--|---|--|
| <input type="checkbox"/> Tub bath/shower | <input type="checkbox"/> Walking | <input type="checkbox"/> Pillows (may bring own) |
| <input type="checkbox"/> Hot/cold compresses | <input type="checkbox"/> Listen to my own music | <input type="checkbox"/> Nitronox (laughing gas) |
| <input type="checkbox"/> Birthing ball/peanut ball | <input type="checkbox"/> Epidural | <input type="checkbox"/> Breathing and relaxation |
| <input type="checkbox"/> Different positions, eg. Side lying | <input type="checkbox"/> Squatting bar | <input type="checkbox"/> Sacred practices/medicine |

Other options: _____



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

After birth, I would like to:

- have delayed cord clamping (if possible)
- have _____ (Name/Pronoun) cut the cord
- have skin-to-skin care for a least one hour after birth (if possible)
- have _____ (Name/Pronoun) hold my baby(ies) skin-to-skin if I am not able to do this myself
- have _____ (Name/Pronoun) take pictures/video
- have _____ (Name/Pronoun) put on the first diaper

If my baby(ies) needs special care, I would like to have _____ (Name/Pronoun) be offered the opportunity to go with my baby(ies) 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(ies): _____

My feeding plan is:

- Breast/chestfeeding Formula feeding
- Pumping and feeding expressed human milk by bottle
- I had problems with breast/chestfeeding a previous baby and would appreciate extra help this time

During my stay in the Postpartum unit, I would like to:

- have _____ (Name/Pronoun) stay with me in my room for support
- be present for any tests or examinations of my baby(ies), eg. Newborn screening
- give the baby's(ies)' first bath with help

I acknowledge receipt of this communication tool.

Date Initials

(YYYY MM DD) _____, NURSE/RM