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# The BirthPlace

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## *Your Birth Plan*

Welcome to The BirthPlace at Longmont United Hospital. In order to better serve you during your stay with us we have put together a Birth Plan that can be customized by you. Please take the time to fill it out and give it to your provider, physician or nurse midwife and discuss it with him/her.

Name: \_\_\_\_\_ Due Date: \_\_\_\_\_

Nickname: \_\_\_\_\_

Other children (names and ages): \_\_\_\_\_

Provider: \_\_\_\_\_

Support person (for labor and delivery): \_\_\_\_\_

Others you wish present at your delivery: \_\_\_\_\_

Provider taking care of your baby in the hospital: \_\_\_\_\_

### **Preparation for Childbirth**

\_\_\_\_\_ I have taken birth classes at \_\_\_\_\_

\_\_\_\_\_ I have not taken classes with this pregnancy.

\_\_\_\_\_ I have not taken classes, but have read a lot.

\_\_\_\_\_ I do not know a lot about labor and delivery.

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

# Changing The *Caring* Experience...



### Preparation for Childbirth (continued)

I am most concerned about: \_\_\_\_\_

The most important part of labor/childbirth experience for me is: \_\_\_\_\_

What I'd really like to avoid is: \_\_\_\_\_

### Support in Labor:

- I am confident in my partner/coach's ability to work with me in labor and expect to need only minimal direction/support from the nurses.
- I have a partner/coach to be with me, but I am planning on considerable nursing support through childbirth.
- I have a person (people) to be with me in labor, but not with labor support experience (or training), so we will need as much help from the nurses as possible.
- I expect to be alone for all or most of my labor and will need considerable nursing support through labor.

Other comments: \_\_\_\_\_

### Plan for Comfort Measures in Labor:

- |  |  |
|--|--|
| <input type="radio"/> Plan to use no medication      | <input type="radio"/> Showers/Jacuzzi      |
| <input type="radio"/> Epidural                       | <input type="radio"/> Walking              |
| <input type="radio"/> Pain medication as needed      | <input type="radio"/> Birthing ball        |
| <input type="radio"/> Open to options as I need them | <input type="radio"/> Breathing techniques |

### I Would Prefer the Following in Labor and Delivery:

- To wear my own clothes in labor.
- To bring music or have a video playing during labor.
- To have my husband or birth partner cut the cord.
- To place the baby on my abdomen as soon as possible after delivery.
- To observe my birth/Cesarean with mirrors.

**Other Options I Would Like to Include in My Birth Plan:**

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**After Delivery**

- I prefer to be discharged earlier than is routine.  
*(This needs to be discussed with "mom and baby" care providers prior to admission.  
Both mother and baby must be approved for early discharge)*
- I would like a massage by a female massage therapist, if available.

**Feedings**

- I plan to breast-feed my baby.
- I plan to bottle-feed my baby. Formula choice: \_\_\_\_\_
- I plan to breast and bottle-feed my baby.
- I do not want my baby to have a pacifier/bottle.
- I want my baby to have a supplement (formula) as needed.

Comments: \_\_\_\_\_  
\_\_\_\_\_

I/we understand that The BirthPlace encourages family-centered care with rooming in and that I/we will be actively involved in the care of my/our baby.

I/we understand that this birth experience and hospital stay can be designed to meet our family's needs only if I express them to the birth attendant and hospital staff.

*I realize that this plan may be changed during labor and delivery if unexpected problems arise.*

**\*\*\* This information needs to be returned to The BirthPlace before labor and after discussing this with your provider. \*\*\***

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_





### *Pre-admission Form*

#### **Patient Information**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Initial: \_\_\_\_\_  
D.O.B. \_\_\_\_\_ Age: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Spouse's Name: \_\_\_\_\_  
Street Address: \_\_\_\_\_ Mailing Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ County: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ SS No.: \_\_\_\_\_  
Maiden Name: \_\_\_\_\_ Patient's Employer: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Day Phone: \_\_\_\_\_ Evening: \_\_\_\_\_  
Do you smoke? \_\_\_\_\_ Allergies? \_\_\_\_\_ Doctor's Name: \_\_\_\_\_  
Probable date of admission: \_\_\_\_\_

#### *Advance Directive*

- Do you have an advance directive?  Yes  No  
Type:  Living Will  Medical Durable Power of Attorney  CPR Directive
- Do you have a copy with you?  Yes  No
  - I will have a copy of my advance directive brought to the hospital.
  - I am not interested in executing an advance directive.
  - I wish to execute a new directive or make changes to my current directive.
  - The hospital may obtain a copy from my previous admission. (Briefly, state the instructions contained within your directive.) \_\_\_\_\_  
\_\_\_\_\_
  - I have received information on advance directives.
  - I would like to speak to someone about executing an advance directive.
  - The information above was completed on a prior admission \_\_\_\_\_  
*Date*
  - No Changes \_\_\_\_\_  
*Month Day Year*

# Changing The *Caring* Experience...

*Mom's Personal History*

- What is your name preference? \_\_\_\_\_
- Do you/your significant other mostly speak a language other than english?  Yes  No  
What language? \_\_\_\_\_
- Do you need an interpreter?  Yes  No
- Do you have any concerns regarding this admission?  Yes  No  
 Past birth experience  Physical/emotional stress  Loss  Abuse  Other  
If yes, please explain: \_\_\_\_\_
- Do you have any religious or cultural preferences that would help us care for you?  
(personal care, food, drink, etc.)  Yes  No  
If yes, please explain: \_\_\_\_\_
- Can we contact someone for spiritual support?  Yes  No  
Name \_\_\_\_\_ # \_\_\_\_\_  Hospital Chaplain
- Do you use any of the following?  Glucose meter  Hearing Aid  TTD  
 Glasses  Contacts  Oxygen  
If yes, please explain: \_\_\_\_\_
- How do you learn best?  Talking  Doing  Watching  Reading
- Have you attended:  Prepared Childbirth  Baby Care  Breast-feeding  CPR  
 \_\_\_\_\_
- If a teen, did you attend a school-parenting program?  Yes  No  
Where? \_\_\_\_\_
- If your birth plan includes adoption, do you wish to be involved with the baby's care?  Yes  No  
Have you chosen an adoption agency?  Yes  No  
Agency: \_\_\_\_\_

*Discharge Plan*

- Do you plan on going to your own home after discharge?  Yes  No  
If not, where? \_\_\_\_\_ # \_\_\_\_\_
- Who will help you at home if you need it? \_\_\_\_\_
- Do you have any concerns about:  Lactation  Returning to work or school  
 Child Care  \_\_\_\_\_  
If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

Patient Signature/Date: \_\_\_\_\_

Nurse Reviewing/Date: \_\_\_\_\_

Staff Signature/Date: \_\_\_\_\_

Changing The *Caring* Experience...

**PRE-REGISTRATION FORM**  
( PLEASE RETURN AT 24 WEEKS OF PREGNANCY)



**PATIENT INFORMATION**

Last Name . . . . . First Name . . . . . Middle Initial . . . . .  
Date of Birth . . . . . Marital Status . . . . . Race . . . . .  
Place of Birth . . . . . Daytime Phone . . . . . Language . . . . .  
Mailing Address . . . . . City . . . . . State . . . . . Zip code . . . . .  
Social Security No. . . . . Employer Name . . . . .  
Employer Address . . . . . Employer Phone . . . . .  
Occupation . . . . . Length of Employment . . . . .

**INSURANCE INFORMATION**

Primary Insurance . . . . . Insurance Phone . . . . .  
Insurance Address . . . . .  
Policy No. . . . . Group No. . . . . If Medicaid . . . . .  
Secondary Insurance  
Primary Insurance . . . . . Insurance Phone . . . . .  
Policy No. . . . . Group# . . . . .

**SUBSCRIBER'S (INSURED) INFORMATION, IF DIFFERENT FROM PATIENT**

Last Name . . . . . First Name . . . . . Middle Initial . . . . .  
Date of Birth . . . . . Social Security No. . . . .  
Mailing Address . . . . . City . . . . . State . . . . . Zip code . . . . .  
Employer Name . . . . .  
Employer Address and Phone . . . . .

**Emergency Contact**

Name . . . . . Relationship . . . . .  
Mailing Address . . . . . City . . . . . State . . . . . Phone . . . . .

**HIPPA/PATIENT CONFIDENTIALITY**

Yes No Can we leave you a message at home? If not, alternate phone number . . . . .  
Yes No Are phone calls and visitors okay while you're here or do you want your visit to be confidential?  
Yes No Do you have a religious preference? If so, would you like a visit from Longmont United  
Hospital clergy or your own? . . . . .  
OB/GYN Physician . . . . . Expected Due Date . . . . . Last Menstrual Period . . . . .

**OPTIONS FOR PRE-REGISTRATION:**

Mail your pre-registration information along with a copy of your insurance card to:

Longmont United Hospital  
Attn: Patient Health Benefit Services  
1950 West Mountain View Avenue  
Longmont, CO 80501

Hand deliver your pre-registration information and a copy of your insurance card to the Registration Department located through the Out-Patient Services entrance at Longmont United Hospital.

Pre-register on-line at the Longmont United Hospital web site; <http://www.luhcares.org>, click on Pre Register Online.

Thank-you!

### *Helpful Preparation Tips*

#### **Prior to labor:**

- register for late-pregnancy classes
- consider renting a pager
- interview pediatricians
- arrange for at-home help if necessary
- plan for your hospital stay by asking family and friends to care for other children and pets, collect mail, etc.
- ask your doctor what the signs and symptoms are at the start of labor so you will know when to call
- pack bags for hospital
- wash baby's new clothes to remove fabric finish
- decide about circumcision

#### **What to Bring to the hospital**

##### *For labor and delivery*

- warm socks
- lip moisturizer
- sour lollipops (women in labor tend to get dehydrated; these produce saliva)
- toothbrush, toothpaste
- camera and film
- playing cards, magazines
- hairbrush
- CDs (player provided)
- DVDs (DVD player provided)
- your favorite pillow

##### *For your recovery, in a separate bag*

- nightgown, robe, slippers
- 2 bras or nursing bras
- toiletry kit
- case for glasses, contact lenses
- address book
- feminine pads
- clothes to wear home (maternity clothes will fit best)

##### *For your baby*

- infant clothes, including an undershirt, blankets and a hat appropriate for the weather
- infant car seat, already installed

Changing The *Caring* Experience...