

UNC Perinatal Hospice Birth Plan

Birth Plan for Baby _____

This birthing plan represents our wishes for labor, delivery, postpartum care and neonatal care for our baby. We have developed this plan with help from the Perinatal Hospice Program through UNC Hospitals and The Center for Maternal and Infant Health. We know that circumstances beyond everyone's control may prevent or change some of things outlined below, but we hope this will serve as a guide for our wishes.

Introduction

Our baby has been prenatally diagnosed with a life threatening condition.

The prenatal ultrasound revealed _____

We had an amniocentesis during pregnancy Yes No

If yes, amniocentesis showed _____

Genetic counseling was provided by _____ (919) 966-2229

Our family has also been assisted through the UNC Perinatal Hospice Program by: _____ (919) _____ - _____

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

1. _____, phone () _____
2. _____, phone () _____

Labor and Delivery

- We have been informed that there is / is not a high risk for stillbirth.
- We want / do not want our baby's heartbeat to be monitored during labor.
- If there is a loss of a heartbeat prior to delivery, we do / do not wish to be informed.
- Preferences for my pain management and medications include:

- We have discussed the issue of C-section with: (please print)

Name	Affiliation	Phone number	Date
Dr. _____,	_____	_____	_____
Dr. _____,	_____	_____	_____
Dr. _____,	_____	_____	_____

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 fetal distress.

- We would like _____ to cut the cord after delivery if possible.
- We request that our baby be handed immediately after delivery to his/her mother or father depending on circumstances.
Yes No
- Because our baby may not survive for very long, please delay any procedures that can be put off until later. We want to have our baby in the room with us for all routine care. We request that as many routine and necessary procedures as possible be performed with our baby in our arms.
Yes No
- We request that a ceremony (blessing, baptism, etc.) be performed in accordance with our religious beliefs by _____
- Special requests include:

Family Members

- We would like _____ to be present for the delivery if possible.
- After delivery, we would like _____ to be able to come into our room and spend time with us and our baby.
- Special requests:

Medical Management of the Infant

We have been informed of the natural history of our baby's diagnosis, and the poor 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,
 - We wish to utilize all medical interventions available in order to prolong our baby's life.

OR

- We wish to utilize 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, NG or OG tube
may be used if our baby cannot suck or swallow. | <input type="checkbox"/> | <input type="checkbox"/> |

Additional testing

For the purpose of chromosome studies or other, special testing, to possibly determine a cause for our baby's condition, please collect:

Amniotic fluid *Placental tissue* *Peripheral blood*
Cord blood *Nothing*

Please see attached instructions for where to send the sample.

Please call the genetic counselor with any questions regarding testing.

Office: (919) 966-2229

Pager: (919) _____ Other contact: _____

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"/> |
| • I would like to use the hospital cremation service
* I understand that ashes are <i>not</i> available to me through this service. | <input type="checkbox"/> | <input type="checkbox"/> |
| • Funeral or private cremation arrangements have been made with a Funeral Home
_____ (name and number of the Funeral Home) | | |

- Other requests:

Special Keepsakes Requested:

<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>

Other requests include:

Signatures of Parent (s): We understand that this plan is meant to provide a guideline of our wishes for the delivery and care of our baby. This may not be able to be followed in its entirety due to extenuating circumstances beyond our control.

_____ (date) _____ (date) _____

This plan was completed after discussion with: (please print)

Name	Title	Phone number	Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____