This BIRTH PLAN represents our wishes for labor, delivery, postpartum, and neonatal care. Your individualized plan will be prepared with help from our Perinatal Palliative Care Team at UNC Hospitals and the Center for Maternal and Infant Health.

We know that our baby may die during or soon after birth. We know that situations can develop that may require changes to our plan, but we ask that this plan serve as a guide for those caring for us and for our baby. We also know that we may change our plans.

Our baby, ________________________________

has been diagnosed with __________________________________________________________

________________________________________________________________________

Mother’s Full Name and MR# Father/Partner’s Full Name

________________________________________________________________________

Siblings Names and Ages

________________________________________________________________________

Other Family who will be with us in the hospital

Obstetrician _________________________ Pediatrician ______________________________

Due date is: ____________________ Induction of Labor date: ________________

Labor and Delivery

- We want / do not want our baby’s heartbeat monitored during labor.
- If there is a loss of the heartbeat prior to delivery, we want / do not wish to be informed.
- Preferences for pain management and medications during labor and delivery are:
  __________________________________________________________________________

- We want / do not want a cesarean section for fetal distress.

- We would like ______________________ to cut the umbilical cord, if possible.
- We request that our baby be handed immediately to mother / father or ______________________
- We would / would not like a ritual (blessing, baptism, naming ceremony) performed after our baby is born. We would like ______________________ (name, phone #) to perform this ritual. A hospital chaplain is also available at all times.
Comfort Care after delivery:

The Labor and Delivery Staff understand that you will want as much time with your baby as possible. They will not do any procedures to you or your baby without discussing it with you first.

Comfort measures may include:
___ Medication (to promote comfort and ease pain)
___ Oxygen
___ Skin-to-skin contact
___ Feeding or other oral comfort measures (pacifiers, breast-milk, formula, sugar-water) and love and special attention by all care providers.

___ We would like our baby to stay in the room as long as possible.
___ We would like to bathe and dress our baby.
___ We would like help from the nurse to bathe/dress our baby.
___ We plan to bring an outfit (the hospital also has special outfits for very small babies)

We understand that the nursing staff can take our baby to the nursery for us for a short time if we need a break.

Breast Care

___ We would like to talk to someone about how to dry up the milk supply.
___ We would like to talk with someone about donating breast milk.

Sibling Education

We understand our other children need to be prepared for the baby’s death.

___ We would like help talking to our children.
___ We have professional support (school counselor, child developmental specialist, pastor or priest, pediatrician) who can help us talk to our other children.
___ We feel comfortable talking about this to our other children ourselves.

Plans for home care

Home care nursing is available for help at home. A nurse, social work and/or chaplain would be involved to help teach you to care for your newborn and provide support to you, your other children, and your family. They provide compassion, understanding, and a level of deep commitment by bringing heartfelt physical, emotional, and spiritual care to families and those living with a life-limiting condition.
**End-of-Life care (if our baby is stillborn)**

Labor and delivery will give you mementos to honor and remember your baby. These mementos will be given in a keepsake carrier with grief pamphlets and information included.

We have made arrangements for a funeral/memorial service at ___________________________.

(Name /phone# of funeral home)

**Additional Testing** is offered to determine, if possible, the cause of baby’s condition

Testing (amniocentesis or CVS) was / was not (circle one) performed during the pregnancy.

Results (if available): _____________________________________________________________

We would like to proceed with testing after delivery to try to determine a cause for our baby’s condition, which may include:

___ physical examination by a pediatric genetics doctor (919-966-4202 or page on-site MD),
___ blood tests (by cord blood if possible)
___ X-rays/MRI
___ Autopsy if the baby dies before leaving the hospital.
___ We would like to discuss testing options further with the physician or genetic counselor before making a decision about further testing.

Additional Requests include: ______________________________________________________

________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

**My Perinatal Care Coordinator is:**

___ Lisa K Welborn, LCSW  984-974-9017 or pager: 919-216-9509
___ Maya Lindley, LCSW  984-974-9019 or pager: 919-216-0177

*Update 1/25/18*