Essential checklist and optional preferences

Why essentials and preferences should be separated

A birth checklist has two jobs that should not be confused. The first is clinical reliability: making sure the care team can rapidly see information that affects safety, triage, medication use, anesthesia planning, neonatal care, and emergency decisions. The second is relational clarity: helping the team understand what makes the birthing person feel respected, informed, and emotionally steady.

In clinical checklist science, effective lists are usually short, focused on critical steps, and tested in the setting where they will be used. A sprawling document can feel thorough, but it may hide the most important items. For birth, that means the first page should not bury a current medication and allergy list under details about music, lighting, or snacks. Those comfort details matter, but they belong in a separate optional section.

This separation also protects preferences from being dismissed. When optional items are labeled clearly, clinicians can honor them when medically appropriate without mistaking them for rigid demands. A concise birth preferences document can say, in effect: these are our values and hopes, and we understand that safety may require adaptation.

Essential clinical information

The essential section should be the part a triage nurse, midwife, obstetric clinician, or anesthesiologist can scan quickly. It should include the birthing person's full name, date of birth, gestational age or estimated due date, obstetric clinician or midwifery practice, chosen birth location, emergency contact, and support person's phone number. Include pregnancy-specific conditions such as hypertensive disorders, diabetes, placenta concerns, fetal growth issues, group B streptococcus status if known, prior cesarean birth, uterine surgery, bleeding disorders, or relevant anesthesia history.

Medication safety deserves its own visible line. List prescription medicines, over-the-counter medicines, supplements, anticoagulants, insulin, antihypertensives, psychiatric medicines, and any medication allergies or adverse reactions. If the person has asthma, seizure disorder, cardiac disease, clotting history, severe anemia, or other chronic conditions, summarize the diagnosis and the clinician managing it.

Essentials should also include key documents and logistics: insurance card, photo identification, prenatal records if not already shared electronically, blood type if known, advance directives if relevant, and infant car seat plan for hospital discharge. For a home birth preparation checklist, essential information should include the home birth transfer plan, nearest hospital, transport method, backup clinician, and when to call emergency services.

Essential labor and birth decisions

Some decisions are preference-shaped but clinically important enough to appear in the essential section. These include whether the birthing person consents to blood products, whether there are religious or cultural considerations that affect urgent care, and who may receive medical updates. If there is a designated decision-maker for rare situations when the patient cannot communicate, document that clearly.

Pain management planning also belongs near the front, especially if anesthesia consultation has been recommended. A person hoping for unmedicated labor may still want to note whether epidural analgesia, nitrous oxide, intravenous

opioids, sterile water injections, or other options have been discussed. The goal is not to prescribe a pain plan in advance; it is to reduce confusion if preferences change during labor.

For people with a prior cesarean birth, prior shoulder dystocia, significant postpartum hemorrhage, complex fetal presentation, or known placental concern, the checklist should prompt a conversation with the care team before labor. The checklist should not attempt to diagnose risk or choose a route of birth independently. It should create a clear place to write the clinician-reviewed plan and the conditions under which the plan may change.

Optional comfort and environment preferences

Optional preferences are not minor; they often shape how safe, calm, and respected a person feels. They are optional because they can be adjusted without usually changing the core medical plan. Examples include room lighting, music, aromatherapy policies, preferred clothing, water or shower use if available, freedom to move when compatible with monitoring, and who is present in the room.

It helps to phrase these as priorities rather than absolutes. For example, instead of stating that continuous monitoring is refused, a person might write that they prefer mobility-compatible monitoring when clinically appropriate. Instead of stating that cervical examinations are not allowed, they might request explanation and consent before each examination unless an emergency prevents discussion.

Optional preferences can also include communication style. Some people want detailed physiologic explanations; others prefer concise choices. A medically literate reader may appreciate terms such as fetal heart rate tracing, oxytocin augmentation, amniotomy, neuraxial analgesia, operative vaginal birth, or cesarean birth, but the checklist should still be readable under stress. Plain language beside medical terminology helps support both precision and compassion.

Newborn and postpartum preferences

Newborn care preferences should be discussed before birth because some are time-sensitive. Common items include immediate skin-to-skin contact if mother

and baby are stable, delayed cord clamping when appropriate, infant feeding intentions, lactation support, donor milk preferences if available, vitamin K, erythromycin eye ointment, hepatitis B vaccination, newborn screening, and circumcision decisions if relevant.

Postpartum preferences should include practical recovery needs as well as emotional support. A postpartum recovery station at home might include pads, perineal care supplies, prescribed or clinician-approved pain relief options, water, snacks, feeding supplies, and emergency contact numbers. In the hospital, preferences may include clustered care for rest, support with first ambulation after neuraxial anesthesia or cesarean birth, and early recognition of postpartum bleeding warning signs.

It is especially important not to frame newborn or postpartum preferences as a test of good parenting. Feeding plans, recovery goals, and bonding routines may change because of hemorrhage, infection concern, neonatal hypoglycemia, respiratory transition, jaundice, maternal exhaustion, or surgical recovery. The checklist should make room for support, not shame. Write the preferred plan, then write acceptable alternatives.

How to build a concise checklist

A practical birth preparation checklist should be short enough to use. One useful structure is three layers: critical information, clinician-reviewed plans, and optional preferences. The critical information section should fit on the first page. Clinician-reviewed plans can include labor management, pain relief, cesarean contingencies, home transfer criteria, and newborn care decisions. Optional preferences can sit on a second page or in clearly labeled subsections.

Borrowing from checklist development principles, each item should earn its place. Ask: would this affect safety, timing, communication, consent, comfort, or discharge? If not, it may belong in a separate notes file rather than the working checklist. Preference checklist research also reminds us that preference tools should be adapted to the target population and context; a hospital checklist, birth center checklist, and home birth checklist will not be identical.

Use specific, actionable wording. Instead of writing that you want respectful care, state what that looks like: explain procedures before performing them, ask before learners enter, use the chosen name and pronouns, and discuss material changes in the plan when time allows. Specific language is easier for the team to honor.

Reviewing and updating before labor

The checklist should be reviewed with the obstetric or midwifery team before the due date, ideally while there is time to clarify facility policies. Ask which items are routinely supported, which depend on staffing or clinical status, and which require advance arrangements. This is particularly relevant for tub use, eating in labor, intermittent auscultation, nitrous oxide availability, photography, additional support people, doula access, and neonatal medication timing.

Bring the checklist to a prenatal visit and ask for direct feedback. A clinician may identify missing medical information, outdated medication details, or a preference that needs a more nuanced discussion. If there is a natural birth checklist and planning goal, it should include backup options for exhaustion, prolonged labor, fetal heart rate concerns, hypertensive disease, infection risk, or unexpected surgical birth.

Update the document after major changes: new diagnosis, new medication, revised induction plan, change in birth location, new support person, or updated neonatal recommendation. Print or store a concise version where support people can find it. The best checklist is not the longest one; it is the one that can be understood quickly when contractions, fatigue, and clinical decisions are already demanding attention.