How to write a birth plan step by step

Step 1: Understand what a birth plan can and cannot do

A birth plan is best viewed as a shared decision-making document. It tells your care team what you prefer when several medically reasonable options are available. For example, you might prefer dim lighting, intermittent position changes, immediate skin-to-skin contact, or a particular approach to pain coping. These preferences can be very meaningful, especially in a busy labor unit where staff may be meeting you for the first time.

At the same time, a birth plan cannot override medical indications. If there is heavy bleeding, severe hypertension, infection, shoulder dystocia, nonreassuring fetal status, or another urgent concern, the team may recommend interventions you hoped to avoid. A flexible plan can still protect your voice by stating that you want explanations, informed consent during labor whenever possible, and involvement of your chosen support person in communication.

Before writing, ask your clinician what is routinely available at your birth setting. Policies vary by hospital, birth center, and home birth practice. Options such as water immersion, nitrous oxide, telemetry fetal monitoring, doulas in the operating room, photography, or delayed cord clamping during cesarean birth may depend on staffing, equipment, anesthesia protocols, and

clinical circumstances.

Step 2: Start with essential identification and medical information

Place the most important practical details at the top. Nurses and clinicians need to understand who you are, who is caring for you, and whether there are medical issues that affect labor management. Keep this section factual and easy to read.

Your name, due date, planned birth location, and clinician or practice name.
Names and phone numbers for your main support person, doula, or other approved visitors.
Relevant obstetric history, such as prior cesarean birth, vaginal birth after cesarean plans, postpartum hemorrhage, shoulder dystocia, severe preeclampsia, or rapid labor.
Medical conditions that may affect care, such as gestational diabetes, chronic hypertension, placenta previa, anticoagulant use, epilepsy, cardiac disease, or group B streptococcus status if known.
Allergies, current medications, blood product preferences, and any religious or cultural considerations that may influence care.

You do not need to include your entire medical chart. Instead, highlight details that could alter decisions about analgesia, mobility, monitoring, antibiotics, hemorrhage risk, or neonatal evaluation. If you have a complex pregnancy, ask your obstetrician or midwife which details should be emphasized.

Step 3: Describe your preferred labor environment

The birth environment can influence comfort, coping, and communication. This part of the plan often includes preferences that are safe when labor is uncomplicated and easily adjusted when clinical care requires it. Consider the sensory details that help you feel calm, focused, and respected.

Who you want in the room, including partner, doula, family members, or interpreters.
Preferences for lighting, music, quiet voices, limited room traffic, or privacy.
Whether you would like to wear your own clothing, use personal comfort items, or have photos or video taken if permitted.

Whether you prefer staff to offer frequent explanations before cervical exams, intravenous access, monitoring adjustments, or medication administration.

This is also a useful place to mention communication needs. For example, you can ask staff to speak directly to you, avoid certain phrases, provide trauma-informed care, or pause for consent before touch unless there is an emergency. If you have a history of trauma, anxiety, pregnancy loss, or a previous difficult birth, consider discussing this privately with your clinician before labor so that supportive care can be planned sensitively.

Step 4: Outline movement, monitoring, and labor coping preferences

Labor preferences should include how you hope to move, rest, and cope with contractions. Many people choose a combination of nonpharmacologic and pharmacologic methods, and it is acceptable to write that you want to decide in the moment.

Examples of nonpharmacologic coping strategies include breathing techniques, massage, counterpressure, hydrotherapy if available, heat or cold packs, birth balls, upright positions, guided relaxation, and continuous labor support. If you hope for mobility, ask whether your birth setting offers mobility-compatible monitoring such as wireless or telemetry monitoring, or whether intermittent auscultation is appropriate for your risk profile.

For pain relief, state your preferences without locking yourself into a single path. You might write that you prefer to begin without epidural analgesia but would like information about options if requested. Or you may prefer early epidural placement, especially if you have a condition where avoiding severe physiologic stress is important. Other options may include intravenous opioids or nitrous oxide, depending on the facility. Discuss contraindications and timing with your clinician and anesthesia team when relevant.

Also include preferences for routine labor care: cervical exam frequency, oral fluids or clear liquids, saline lock or IV fluids, artificial rupture of membranes, oxytocin augmentation, and fetal monitoring. Your clinician can explain which items are optional in your situation and which may be recommended because of maternal or fetal risk factors.

Step 5: Write preferences for pushing and vaginal birth

The second stage of labor can involve many choices, depending on fetal status, maternal energy, epidural use, and the baby's position. Your plan can state preferences for pushing positions, coaching style, and perineal support while acknowledging that recommendations may change.

Preferred pushing positions, such as side-lying, hands-and-knees, squatting, semi-reclined, or using a birth bar if available.
Whether you prefer spontaneous pushing, also called following your body's urge, or coached pushing if needed.
Whether you would like a mirror, to touch the baby's head as it crowns, or to avoid seeing the birth.
Preferences around warm compresses, perineal support, and avoiding episiotomy unless clinically indicated.
Who should announce the baby's sex if not already known.

If operative vaginal delivery becomes necessary, such as vacuum or forceps delivery, your team should explain the indication, benefits, risks, and alternatives when time allows. You can include a request for clear communication before operative assistance, episiotomy, or urgent transfer to the operating room. These statements reinforce consent-centered care while recognizing that emergencies may require rapid action.

Step 6: Include cesarean birth preferences and contingency plans

Even if you are planning a vaginal birth, it is wise to include cesarean birth preferences. This does not mean you expect a cesarean; it means you have considered how to preserve dignity, bonding, and communication if surgery becomes the safest option.

For a planned or unplanned cesarean, you may want to address anesthesia communication, presence of a support person, music if allowed, a clear drape or lowered drape at birth, immediate skin-to-skin contact when clinically safe, delayed cord clamping if feasible, and who stays with the baby if the newborn needs evaluation. Ask your hospital which practices are available in the operating room and recovery area.

If you have had a prior cesarean, your plan should align with your individualized counseling. Preferences for trial of labor after cesarean, repeat cesarean, or vaginal birth after cesarean depend on uterine incision history, facility resources, prior complications, and current pregnancy factors. This part of the birth plan should be reviewed directly with your obstetrician, because emergency surgical capability and continuous monitoring recommendations may apply.

Contingency planning can reduce fear. You might write, "If the plan needs to change for safety, please explain what is happening, what alternatives exist, and how my support person can stay involved." This simple statement helps preserve trust during stressful moments.

Step 7: Add newborn care preferences

The first hour after birth is clinically important and emotionally powerful. Newborn care preferences should be specific but flexible, especially because some babies need extra assessment, respiratory support, glucose monitoring, or neonatal intensive care.

Immediate skin-to-skin contact after vaginal or cesarean birth when mother and baby are stable.
Delayed cord clamping, if appropriate for the clinical situation.
Feeding plans, including breastfeeding, chestfeeding, formula feeding, expressed colostrum, or donor milk if available and indicated.
Whether routine newborn medications and procedures should be done at the bedside when possible.
Preferences about newborn bath timing, rooming-in, pacifier use, and who accompanies the baby for any necessary evaluation.

Discuss vitamin K, erythromycin eye ointment, hepatitis B vaccination, newborn screening, blood glucose checks, and circumcision decisions with your baby’s clinician or birth team before delivery. A birth plan can state your preferences, but it should also make clear that you want evidence-based recommendations if the newborn has hypoglycemia risk, infection risk, jaundice, breathing difficulty, or other clinical concerns.

Step 8: Format, review, and share the final plan

A birth plan works best when it is short. Aim for one page if possible, using clear headings and bullet points. Put the highest-priority items first, such as allergies, major medical history, consent preferences, support people, pain relief preferences, and newborn care priorities. Avoid long paragraphs of explanation; the goal is quick reading during labor.

Before finalizing it, review the plan with your obstetrician or midwife during a prenatal visit, ideally in the third trimester. Ask which preferences are routine, which require special arrangements, and which may not be available at your chosen location. If you have a doula, childbirth educator, anesthesiology consultation, maternal-fetal medicine specialist, or pediatric specialist involved, ask whether they see any gaps.

Bring printed copies to the hospital or birth center, upload it to the patient portal if your system allows, and keep a copy in your birth bag. Give one to your support person so they can advocate for your preferences if you are tired, medicated, or focused on labor. Most importantly, treat the plan as a conversation starter. The best birth plans communicate your values while supporting safe, responsive care for you and your baby.