Simple template and one-page birth plan examples

What a simple birth plan should do

A simple birth plan should make your values visible without trying to predict every possible clinical pathway. In practice, it is a short summary of preferences for labor support, analgesia, interventions, delivery, and newborn care preferences. It helps the team know, for example, whether you hope to move freely, prefer minimal cervical checks, want an epidural early, or would like immediate skin-to-skin contact if mother and baby are stable.

The most effective plan is written as a set of preferences rather than demands. Birth can shift quickly because of fetal heart rate abnormalities, infection concern, hypertensive disease, bleeding, prolonged labor, malpresentation, or other medical findings. ACOG’s sample template frames the birth plan as a guideline and a starting point for conversation, which is the safest mindset.

Try to limit the document to one page, with large headings and short lines. Labor and delivery teams often meet you during active labor, shift changes, or urgent moments. A clear format supports informed consent during labor because it helps clinicians explain which options fit the current situation and which may no longer be advisable.

A one-page birth plan template

Use the template below as a compact structure. You can paste it into a document, delete anything that does not apply, and bring a printed copy to a prenatal visit before taking it to the hospital or birth center.

Name, due date, clinician, and support people: Include your preferred name, pronouns if relevant, gestational age, primary obstetric or midwifery practice, doula, partner, and emergency contact.
Relevant medical information: Note key items your team should already know but may need quickly, such as prior cesarean birth, group B streptococcus status, medication allergies, diabetes, hypertensive disorders, placenta concerns, anticoagulant use, or significant anesthesia history.
Labor environment: Preferences may include dim lighting, quiet voices when possible, limited visitors, music, aromatherapy if permitted, birth ball, shower, tub, or freedom to change positions.
Monitoring and movement: State whether you prefer mobility-compatible monitoring, intermittent auscultation if appropriate, or continuous electronic fetal monitoring when medically indicated.
Pain relief: List desired coping tools such as breathing, counterpressure, hydrotherapy, sterile water injections if offered, nitrous oxide, intravenous medication, or epidural analgesia.
Delivery preferences: Include pushing positions, coached versus spontaneous pushing, mirror use, perineal support, episiotomy only if medically necessary, operative vaginal delivery discussion, and delayed cord clamping when safe.
Baby care: Include skin-to-skin contact, feeding plan, vitamin K, eye prophylaxis, hepatitis B vaccination, rooming-in, circumcision preference if relevant, and who may accompany the baby if transfer is needed.
If plans change: Add cesarean birth preferences, such as having your support person present if safe, clear explanation of anesthesia, skin-to-skin in the operating room when feasible, and early lactation support.

Example 1: low-intervention vaginal birth plan

This example may fit someone hoping for physiologic vaginal birth while still accepting medical monitoring and intervention if needed.

My priorities: I hope for a calm, low-intervention labor with mobility,

privacy, and continuous support. Please discuss recommended interventions with me when time allows, including benefits, risks, and alternatives.

Labor: I would like to move freely, use upright positions, a birth ball, shower, breathing techniques, and counterpressure. If maternal and fetal status are reassuring, I prefer intermittent fetal assessment or wireless monitoring when available. I would like cervical exams only when clinically useful or when I request them.

Pain relief: Please offer nonpharmacologic coping strategies first. I am open to medication or epidural analgesia if I request it or if my clinical situation changes.

Birth: I prefer spontaneous pushing and position changes unless there is a reason to guide pushing. I prefer to avoid episiotomy unless medically necessary. If possible, I would like delayed cord clamping and immediate skin-to-skin contact.

Newborn: I plan to breastfeed and would like lactation help early. I want routine newborn medications and screening explained before administration, and I prefer rooming-in unless observation or treatment is needed.

Example 2: epidural-friendly or induction birth plan

A birth plan is not only for unmedicated labor. If you are planning an induction or expect to use epidural analgesia, a short plan can still clarify comfort, communication, and postpartum goals.

My priorities: I understand induction may involve cervical ripening, oxytocin, amniotomy, and continuous fetal monitoring depending on my situation. I would like explanations before each step and time for questions when medically safe.

Labor: I would like to use movement, position changes, a peanut ball, and rest periods as much as possible. If continuous monitoring is required, I would appreciate help finding positions that support fetal descent and maternal comfort. Please cluster care overnight when safe so I can sleep.

Pain relief: I am open to epidural analgesia. Before placement, I would like

information about expected effects, possible hypotension, urinary catheter use, motor block, and how the team monitors maternal blood pressure and fetal status afterward.

Delivery: I would like guidance on pushing with an epidural, including laboring down if appropriate. If vacuum or forceps delivery is recommended, please explain the indication and alternatives if time allows.

Postpartum: If baby and I are stable, I want skin-to-skin, delayed newborn measurements, and support for the first feeding. If I am exhausted or medically unwell, my support person may assist with newborn care.

Example 3: planned cesarean or cesarean contingency plan

Even if you are planning a vaginal birth, cesarean birth preferences can reduce anxiety if an operative birth becomes necessary. A cesarean may be planned for placenta previa, certain fetal presentations, prior uterine surgery, multiple gestation considerations, or other indications; it may also occur urgently for maternal or fetal concerns.

My priorities: If cesarean birth is recommended, I would like a clear explanation of the reason, urgency level, anesthesia plan, and what to expect in the operating room. I understand that emergencies may limit discussion.

Operating room: I would like my support person present if permitted and safe. Please tell me what sensations are normal with neuraxial anesthesia, such as pressure or tugging, and what symptoms I should report immediately. If possible, I prefer a calm environment and updates during the procedure.

Baby contact: If baby is vigorous and I am stable, I would like skin-to-skin contact in the operating room or recovery area. If separation is needed, my support person may accompany the baby if allowed.

Feeding and recovery: I plan to feed my baby as soon as feasible and would like lactation support. Please explain pain control options, early ambulation, venous thromboembolism prevention, incision care, and warning signs before discharge.

How to keep the plan flexible and medically useful

A strong plan makes preferences easy to honor and safety concerns easy to address. Use phrases such as "if clinically appropriate," "when mother and baby are stable," and "please explain if this is not recommended." These statements show that you value shared decision-making while recognizing that obstetric care can change rapidly.

Before finalizing the plan, ask your care team what is routinely available at your birth location. Not every unit offers nitrous oxide, tubs, wireless monitoring, gentle cesarean drapes, or immediate skin-to-skin in the operating room. Some preferences may depend on staffing, infection policies, anesthesia availability, neonatal status, or maternal risk factors.

It can help to rank your top three priorities. For one person, those may be epidural access, clear communication, and partner presence. For another, they may be mobility, delayed cord clamping, and avoiding unnecessary separation from the baby. If complications arise, your top priorities guide the team toward what still matters most.

Bring copies for admission, but also discuss the plan during prenatal care. Your clinician can flag items that conflict with your medical history or local policy. This is especially important for trial of labor after cesarean, planned out-of-hospital birth, insulin-requiring diabetes, hypertensive disease, fetal growth restriction, anticoagulant use, or anticipated neonatal needs.

Common mistakes to avoid

One common mistake is writing a plan so long that the key preferences disappear. A three-page document can be thoughtful, but it may be hard to use during active labor. Keep background explanations brief and focus on decisions the team can act on.

Another mistake is using absolute language about interventions. Statements such as "no monitoring," "no IV under any circumstances," or "never cesarean" can create conflict if a safety issue develops. More useful wording is specific and conditional: "I prefer to avoid routine IV fluids unless indicated," or "I would like to discuss cesarean birth if it becomes recommended."

A third mistake is omitting newborn care. The first hour after birth can include thermoregulation, airway assessment, Apgar scoring, cord management, feeding, medication decisions, and evaluation for hypoglycemia or infection risk. If your baby needs resuscitation, oxygen support, glucose monitoring, antibiotics, or neonatal intensive care, clinical needs take priority, but your preferences about communication and support person involvement still matter.

Finally, avoid treating the birth plan as a measure of success. A satisfying birth is not defined by how closely events match the page. It is often shaped by respectful communication, timely care, emotional support, and feeling that your questions were heard even when the plan had to change.