

When to call your doctor based on labor signs



Start with your personal birth plan and risk profile

The best time to clarify when to call your doctor is before contractions begin. General labor guidance is useful, but your own threshold may be different if you have a high-risk pregnancy, a planned induction or cesarean birth, group B streptococcus colonization, placenta concerns, hypertension, diabetes, a history of preterm birth, multiple gestation, reduced fetal growth, or a previous very rapid delivery. Your clinician may want you to call earlier than standard timing rules suggest.

Ask your obstetrician, midwife, or maternity unit for written instructions that answer four practical questions: who to call during office hours, who to call overnight, when to go directly to the hospital or birth center, and when to call emergency services. Keep that number visible in your phone and share it with your support person. If you are unsure whether a symptom is significant, it is appropriate to call. Maternity triage teams expect uncertainty; they would rather help you decide early than have you wait through a potentially important warning sign.

Contractions: when timing becomes a reason to call

True labor contractions usually develop a pattern. They tend to become stronger, longer, and closer together, and they often continue despite hydration, rest, position changes, or a warm shower. Braxton Hicks contractions, by contrast, are often irregular, may ease with movement or fluids, and do not consistently intensify. This distinction is not always obvious, especially in first pregnancies, so contraction timing is a helpful but imperfect tool.

Many maternity units use a version of the 5-1-1 rule for first-time labor: contractions about every 5 minutes, lasting about 1 minute each, continuing for at least 1 hour. Some units recommend a different threshold for people who have given birth before, such as calling when contractions are regular every 7 to 10 minutes, because later labors may progress faster. Your local instructions may vary.

Call sooner if contractions are very painful from the start, if you cannot talk through them, if you feel rectal pressure or an urge to push, or if travel time to your birthplace is long. Also call if your contraction timing pattern is regular before 37 weeks, because that may suggest preterm labor and needs prompt guidance.

Water breaking: call even without contractions

Rupture of membranes, often called your water breaking, may feel like a sudden gush or a slow continuous trickle. It can be difficult to distinguish amniotic fluid from urine or increased vaginal discharge, but persistent leaking is a reason to contact your doctor, midwife, or maternity unit. Do not wait for contractions to become regular before calling unless your care team has specifically told you to do so.

When you call, note the time leaking began, the amount of fluid, the color, and whether there is an odor. Clear or pale fluid can occur with normal rupture of membranes. Green or brown amniotic fluid may indicate meconium, which means the baby has passed stool before birth and should be assessed by maternity professionals. Bloody fluid, foul-smelling fluid, or fluid accompanied by fever or significant pain also needs urgent contact.

After membranes rupture, your team may give instructions based on gestational

age, group B strep status, contraction pattern, fetal movement, and your local hospital policy. Avoid inserting anything into the vagina unless your clinician instructs otherwise, because reducing unnecessary vaginal exposure can help limit infection risk.

Bleeding, bloody show, and mucus plug changes

A small amount of blood-tinged mucus near term can be normal. This is often called bloody show before labor and may happen as the cervix softens, thins, or begins to open. Losing the mucus plug can look like thick clear, pink, or brown discharge. By itself, this does not always mean active labor is imminent, and it may occur hours, days, or even longer before birth.

Heavy vaginal bleeding is different. Call immediately or seek urgent care if bleeding is like a period, soaks a pad, contains clots, is bright red and ongoing, or occurs with abdominal pain, dizziness, faintness, or decreased fetal movement. Significant bleeding can have causes that require immediate assessment, and it is not something to monitor at home without guidance.

If you are unsure whether what you see is mucus, spotting, or bleeding, call and describe it plainly: color, amount, whether it is mixed with mucus or watery fluid, whether it continues, and whether the baby is moving normally. Photos are not always necessary, but some triage services may ask for one through a secure system if available.

Fetal movement changes should be taken seriously

Call your doctor, midwife, or maternity unit promptly if you notice decreased fetal movement, absent movement, or a clear change from your baby's usual pattern. Babies do not normally stop moving because labor is near. Movement quality can feel different near the end of pregnancy because space is tighter, but the baby should still have regular periods of activity.

If your care team has taught you kick counts or another movement-awareness method, follow those instructions. If you have not been given a specific method and you feel concerned, do not spend hours trying multiple home strategies before calling. Eating, drinking, or lying on your side may help you focus on movement, but persistent concern is enough reason to seek advice.

Reduced fetal movement near term can have benign explanations, but it can also be an early sign that the baby needs evaluation. Maternity units can assess fetal well-being with monitoring and decide whether further testing is needed. Trust your knowledge of your baby's normal pattern; your concern is clinically relevant information.

Pain, fever, and symptoms that are not typical labor

Labor contractions are painful for many people, but pain that is constant, severe, or does not come and go like a contraction deserves prompt attention. Call immediately for intense abdominal pain between contractions, severe headache, visual symptoms, chest pain, shortness of breath, fainting, seizures, or sudden swelling of the face or hands. These symptoms are not routine labor signs and may require urgent assessment.

Fever, chills, flu-like illness, or a foul-smelling vaginal discharge should also prompt a call, especially after membranes have ruptured. Infection risk can rise after the amniotic sac opens, and fever in labor affects both maternal and fetal monitoring decisions. Persistent vomiting in late pregnancy can also matter if you cannot keep fluids down, feel weak, or have signs of dehydration.

Back pain alone can be part of labor, particularly if the baby is positioned in a way that increases pressure on the lower spine. However, back pain with regular contractions before 37 weeks, urinary symptoms, fever, bleeding, or fluid leakage should be discussed with a professional. When symptoms do not fit your expected contraction pattern, call rather than trying to interpret them alone.

Preterm labor and special situations

Before 37 weeks, call your doctor or maternity unit for signs of preterm labor, including regular contractions, menstrual-like cramping, low backache, pelvic pressure, vaginal bleeding, fluid leakage, or a notable increase in watery or mucus-like discharge. Preterm labor warning signs can be subtle, and early assessment may change management options.

You should also call earlier if you have a known placental issue, a cerclage,

twins or higher-order multiples, ruptured membranes, high blood pressure symptoms, or a prior preterm birth. If you live far from your hospital, have a history of fast labor, or have been told the baby is breech or in another non-head-down position, your team may want earlier evaluation when labor signs begin.

If you are scheduled for a cesarean birth and labor starts before the planned date, contact your maternity unit right away. The same applies if you are planning a vaginal birth after cesarean; your team may want to know as soon as contractions are regular, membranes rupture, or pain feels unusual. These calls do not mean something is wrong; they help the team align your plan with what your body is doing.

What to say when you call

When you contact your doctor or maternity triage, concise details help the team decide what you need next. Have your gestational age, due date, pregnancy complications, group B strep status if known, and planned birthplace ready. If contractions are the concern, share when they started, how far apart they are from the start of one contraction to the start of the next, how long they last, and whether the pattern is changing.

If fluid is leaking, report the time it began, color, amount, odor, and whether contractions or fever are present. If bleeding is present, describe the color, amount, clots, and associated pain or dizziness. If fetal movement has changed, explain what is different from normal and when you last felt reassuring movement.

While waiting for instructions, avoid driving yourself if you are in significant pain, feel faint, or think birth may be close. Keep your phone available, gather your hospital bag if appropriate, and follow the triage team's advice about whether to stay home briefly, come in for assessment, or seek emergency care. Calling is not a commitment to admission; it is a safety step.