

When to go to hospital and transport planning



Start with your individualized hospital threshold

The right time to go to hospital is not identical for every birth. Your threshold depends on gestational age, obstetric history, distance from care, current pregnancy risks, fetal status, membrane rupture, and whether you have had a previous rapid labor. A person planning a first vaginal birth close to the hospital may safely remain at home longer in early labor, while someone with a history of precipitous birth, placenta-related bleeding, hypertensive disease, insulin-treated diabetes, multiple pregnancy, breech presentation, or planned cesarean may be advised to come in sooner.

Before labor begins, ask your maternity team for a written or clearly remembered plan: which number to call, which entrance to use, where to go after hours, and whether you should call before leaving. Many hospitals use telephone triage to decide whether you need immediate assessment, can continue at home, or should call emergency medical services.

In uncomplicated term labor, many teams use contraction timing as one part of the decision. A common framework is the 5-1-1 rule for contractions: contractions about five minutes apart, lasting about one minute, continuing for one hour. However, this is not a safety rule by itself. You may need assessment

before that point if pain is unusually severe, the baby is moving less, your water breaks with concerning fluid, you have bleeding, you feel unwell, or you are preterm.

Labor signs that usually mean it is time to call or go in

For many people, labor begins gradually with irregular contractions, backache, pelvic pressure, mucus discharge, or a small bloody show. These can be normal, especially near term. The decision to leave home usually becomes clearer when contractions are regular, progressively stronger, and difficult to talk through, or when your maternity unit advises assessment based on your history.

Call your hospital or midwife promptly if you have water breaking without contractions, because they may want to confirm membrane rupture, check fetal wellbeing, review infection risk, and discuss timing. Go in sooner if the fluid is green or brown amniotic fluid, foul-smelling, or accompanied by fever, uterine tenderness, or reduced fetal movement near term. Meconium-stained fluid can be benign in some settings but may also signal fetal stress and should be assessed by professionals.

Preterm labor before 37 weeks is different from term labor. Regular painful contractions, pelvic pressure, back pain, abdominal cramping, bleeding, or fluid leakage before term should trigger urgent contact with your maternity team. Do not wait for contractions to meet a term-labor pattern if your pregnancy is preterm.

If you are group B streptococcus positive, have a planned antibiotic protocol, or have medical conditions requiring early monitoring, your team may recommend coming earlier after membrane rupture or established labor. The goal is not to medicalize every sensation, but to match timing to your clinical risk.

Warning signs that require urgent hospital assessment

Some symptoms in pregnancy, labor, or postpartum should bypass routine timing rules. Seek urgent hospital assessment in pregnancy if you have heavy vaginal bleeding, severe abdominal pain that does not ease between contractions, seizures, fainting, severe allergic reaction, sudden severe headache, neurological symptoms, chest pain, significant shortness of breath, or signs of

shock such as clamminess, confusion, or collapse.

Emergency medicine guidance consistently treats symptoms such as trouble breathing, chest pain, stroke signs, seizures, poisoning, loss of consciousness, severe trauma, suicidal or homicidal thoughts, and sudden severe headache as requiring emergency evaluation. In the birth context, these symptoms are not explained away by pregnancy or labor; they still need immediate medical attention.

For the baby, reduced fetal movement near term deserves prompt advice. Fetal movement patterns vary, but a noticeable decrease, absence of movement, or a pattern that worries you should be taken seriously. Do not rely on home devices or reassurance from previous normal scans. The maternity unit can perform appropriate fetal assessment.

After birth, urgent symptoms include heavy vaginal bleeding after birth, passing large clots with dizziness or weakness, fever with feeling very unwell, worsening abdominal or pelvic pain, chest pain, difficulty breathing, severe headache with visual changes, new swelling with hypertension concerns, calf pain with swelling, or cesarean wound infection symptoms such as spreading redness, pus, fever, or increasing wound pain. Postpartum hemorrhage warning signs and postpartum sepsis warning signs can progress quickly, so early escalation is protective.

Ambulance, private car, taxi, or ride share: choosing the safest transport

Transport choice is a clinical safety decision, not just a convenience decision. If you have life-threatening symptoms, call emergency services. Ambulance crews can provide assessment, oxygen, bleeding control, resuscitation support, and rapid communication with the receiving hospital. They also reduce the danger of a distressed support person driving while distracted.

Ambulance transport is usually the safer choice for difficulty breathing, crushing or persistent chest pain, signs of stroke such as facial droop or one-sided weakness, seizure, loss of consciousness, severe injury that limits mobility, suspected poisoning, major bleeding, severe confusion, or imminent birth when you cannot safely reach the hospital. If the birthing person feels an urge to push, has visible crowning, or cannot move safely, call emergency

services and follow dispatcher instructions.

Private car transport may be reasonable for stable labor when you have spoken with triage, symptoms are not life-threatening, and you have a safe driver. The laboring person should not drive. Contractions, pain, rupture of membranes, dizziness, or sudden progression can make driving unsafe. A taxi or ride share may work for routine transport if local policy permits, but it is not appropriate for heavy bleeding, severe pain, collapse, suspected emergency birth, or any condition requiring medical support en route.

If using a private vehicle, place absorbent pads or towels on the seat, keep the hospital bag accessible, and use a seat belt correctly: lap belt low across the hips, shoulder belt between the breasts and to the side of the abdomen. Avoid lying flat in the back seat unless specifically advised; safety restraint matters even during contractions.

Build a practical transport plan before labor

A good transport plan is simple enough to use at 3 a.m. while contractions are intensifying. Write down the maternity triage number, emergency number, hospital address, preferred entrance, parking location, after-hours door, and unit name. Save the information in each support person's phone and keep a paper copy in the hospital bag in case a phone battery dies.

Plan at least two routes to the hospital and check typical travel times at different times of day. Consider school runs, sporting events, roadworks, severe weather, snow, flooding, or rural access issues. If you live far from the hospital, ask your clinician whether you should relocate closer near term, present earlier in labor, or have a lower threshold for calling emergency services.

Choose a primary driver and a backup driver who can be reached day or night. Arrange childcare, pet care, and key access without depending on one person only.

Keep fuel or charging level adequate from late pregnancy onward.

Prepare payment methods for parking, taxi, or unexpected transport costs.

Pack documents, medication list, allergy information, prenatal records if needed, and chargers.

If you have high-risk features, ask whether the hospital wants advance notice when you are coming. For example, planned surgical birth, placenta previa or accreta concern, significant anemia, anticoagulant use, or previous emergency cesarean hemorrhage planning may change how the unit prepares for your arrival.

Special situations: rapid labor, distance, home birth transfer, and postpartum return

People with previous rapid labor should discuss a modified plan. If earlier births moved from mild contractions to pushing quickly, waiting for classic contraction spacing may be unsafe. Your team may recommend leaving when contractions become regular, when membranes rupture, or at the first signs that labor resembles your prior pattern.

If you planned a home birth or birth center birth, transport planning should be explicit rather than improvised. Know which hospital accepts transfers, who calls ahead, who rides with the birthing person, and what records travel with you. Transfer does not mean failure; it is a safety pathway when pain relief, continuous fetal heart rate monitoring, operative birth, blood products, neonatal support, or maternal treatment becomes necessary.

For people in remote areas, transport planning may include earlier departure, temporary accommodation near the hospital, community ambulance limitations, winter travel arrangements, or air transport protocols in rare cases. Discuss these realities before 37 weeks, especially if there are fetal growth concerns, hypertensive disorders, bleeding risk, or previous surgical complications.

Do not stop transport planning once the baby is born. The postpartum period carries risks such as hemorrhage, infection, thromboembolism, hypertensive complications, and mental health emergencies. If you are advised to return to hospital, avoid driving yourself if you are dizzy, in severe pain, sleep-deprived, taking sedating medication, or actively bleeding. Call emergency services for collapse, severe breathing difficulty, chest pain, seizures, severe confusion, suicidal thoughts, or heavy bleeding with weakness.