Getting Ready for Labor

Hoffman and Associates OB/GYN

Now that you have entered your third trimester, there are a lot of things to think about before your delivery. This is intended to provide you with general information and to help you think ahead. This handout may seem detailed, but we feel the information we have included is both important and useful.

What you can expect: Starting about 28 weeks (or 7 months), you can expect to start getting more uncomfortable. You will have more pelvic pressure. If this is your second or third baby, it may feel like a bowling ball is pushing down in your pelvis by 32 weeks. Women will come in and swear they are going to squish the baby if they sit down. That's because the muscles in your pelvis have been stretched from a prior pregnancy (even if it ended in a C-section). Just like your stomach popped out much sooner, you carry the baby much lower. Your back also will start to hurt more. The natural curvature of your spine becomes more pronounced (called lordosis) and causes muscle strain. Taking a hot bath for 20 or 30 minutes at night may help with both the pelvic pressure and the back pain. Using a heating pad on a low setting also may help with backaches.

You also don't sleep as well because of the pelvic pressure, backache and need to urinate frequently. Your body will start to ache and/or fall asleep if you are in one position too long. You may want to decrease what you drink after 7 or 8 pm and cut out caffeine completely after 5 or 6 pm. This will decrease the amount of urine you make. You may have trouble finding a comfortable position to sleep in. If you are lying on your back and start to feel nauseated or lightheaded, that's a sign you need to be sleeping on your side. It's from your pregnant uterus pressing on the vessel bringing blood back to your heart, leading to less blood and oxygen leaving your heart causing you to feel sick and dizzy. Try using a body pillow or several pillows. Some women end up sleeping in recliners the last several weeks of the pregnancy.

You will get more indigestion. Your uterus is pushing upward and causing your stomach to get pushed up leading to more indigestion and reflux. Eating smaller, frequent meals may help. Eating at least 3 hours before going to bed and sleeping with extra pillows or elevating the head of your bed may help. Maalox, Mylanta and Tums may not be enough. You may need Zantac or Pepcid AC or Reglan.

You may become short of breath - even walking up a few steps or walking around at work. Slow your pace but keep moving. The more you move and exercise throughout the pregnancy, the better you tolerate labor. Remember, it's called labor because it is "hard work."

Stretch marks may start to show. Your skin can only stretch so much. The more weight you gain, the worse the stretch marks can be. There is nothing to help prevent them while you are pregnant but a good moisturizing lotion can help with the itching or burning you may experience. You can even use 1% hydrocortisone cream.

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Swelling in your legs is universal. It is gravity pulling the extra fluid you have to the lowest part of your body. If you are older or it is hot and humid, the swelling is much worse. July, August and September can be very uncomfortable months because of the heat and the swelling that follows. Stay out of the heat, stay hydrated (please drink at least 8 or 10 large glasses of water outside of meals every day), avoid salt and salty snacks and keep your feet elevated. During lunch at work, put your feet up (higher than your hips) if possible. At bedtime, put a pillow under your feet (getting them higher than your hips). You can use Ted stockings (calf high or thigh high) but they can get hot in the summer months.

Varicose veins appear as well. They are much more common in the second or third pregnancy than the first. You can get them in your legs and even in your labia (outside of your vagina). They can feel full and "throbby," especially if you are on your feet a lot. Ted stockings can help with these too. For severe vulvar varicosities, there are "girdle type" wraps that are available online.

Paging your doctor: If you are having an emergency, please have us paged. Please keep your phone near you and open for at least 30 minutes after calling. When we call you back, it may come up as a blocked or unknown call. Please take the call. We have our phone blocked because patients have saved our numbers and called us back at all hours of the day and night. If we have not returned the page within 30 minutes, please call the answering service again. They can page us again. Occasionally, there have been issues with pages not going through. More often, if we are delivering a baby, it may take us a little longer to get back to you. It is our intention to return every page as quickly as we can. Also, please don't have your spouse or significant other page us and expect us to speak with them. You are our patient, you are the pregnant one and we need to talk with you. If you are definitely going to the hospital (i.e. you know you are in labor/your water broke), you don't need to page us. The midwife will page us once you have been seen and we can decide what to do next. You are seen in triage according to medical acuity (ie actively laboring patient will be seen before "I have a discharge" or "I lost my mucous plug" - neither of which belong in L&D). Triage is NOT "First come, first serve." This is treated like a regular ER visit. If others are taken ahead of you, there is a good reason. Please don't argue with the staff about who is being seen first. If we limit triage to ONLY this patients that need to be there, it will reduce the waiting for everyone.

Preterm labor signs: Contractions can feel like your belly tightening and sometimes women say "the baby is balling up." If the baby "balls up" in one spot, that's fine. If your whole belly balls up and gets hard, that's a contraction. It does not have to hurt. If you have more than 4 or 5 contractions in an hour and you are less than 35 weeks, drink a big glass of water (approximately 40 ounces) and get off your feet. If the contractions do not space out or they get stronger, call us. Being well hydrated will stop the "fake" contractions that can bring you to Labor & Delivery. If you haven't eaten for hours and are having these contractions, eating can help stop them too. If you have recently had sex, allow a little more time for them to go away. It is common for your uterus to tighten up or contract after sex. In fact, sex is the one thing you can do to help go into labor after 37 weeks. The prostaglandins in the semen from a man cause your cervix to soften and thin and can lead to labor. If you are being treated for preterm labor, don't have sex until after 35 weeks. If you are more than 35 weeks and have not been told otherwise, feel free to have sex. It's not always the most comfortable and finding a position that works well can be challenging but it is safe and good for you and your partner to stay connected.

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Feeling the baby move: It is not unusual for the movement you feel from the baby to change around 35 to 37 weeks. It's gets more crowded as the baby gets bigger and it doesn't have the space for big kicks and punches. Often, the movement feels more like "squirming around". If you feel like you have not felt the baby move in several hours, please drink something cold, eat something sweet and lie down in a quiet area. Do not talk on the phone or watch TV - count movements. If you feel 2 or 3 movements in 20 minutes after eating and drinking, everything is fine. If you feel no movement, please head to Labor & Delivery to be monitored. L&D is open 24-hours a day. We would rather you go there 100 times and everything be okay then stay at home and find out there is a problem. If you are getting in the car to come to the hospital, put your seat belt on and feel the baby move, then you don't need to come in. The tightness from the seatbelt can help you feel the baby better.

History of herpes: Many of our pregnant patients have Herpes (about 25%). This does not mean you need a C-section. But, it does require that we start you on medication (either Valtrex or Acyclovir) several times a day starting about 35 weeks. This will prevent an outbreak and prevent asymptomatic shedding and allow you to safely deliver your baby vaginally. If you have an outbreak and break your water or are in labor, you will need to have a C-section. If you know you have Herpes or think you may, please tell us. There are blood tests we can do to confirm the diagnosis or show that you don't have Herpes. If you get exposed to Herpes or think you may have been infected while you are pregnant, please see us as soon as possible to be evaluated. If your partner has Herpes, your risk for getting Herpes is greater so please let us know. We want to protect your baby from getting infected. Please don't let embarrassment be a barrier to taking care of you and your baby. Having Herpes is nothing to be embarrassed about but if we don't know, we can't provide the best care of you and your baby. Valtrex dosing is 500 mg twice a day. Acyclovir dosing is 400 mg three times day.

Your mucous plug: Your mucous plug will look like you blew your nose in your underwear - literally. It is a collection of snotty looking stuff - sometimes with red or brown blood - that some women will pass prior to labor. Other times, women will lose the plug over days and days. You can see lots of slimy, snotty discharge every time you wipe. You DO NOT need to call us at the office or have us paged as an emergency or head to L&D. It is normal and doesn't require any extra attention. It does not mean the baby is coming within a few days. It can frequently be seen weeks before the baby is born.

Visits to Labor & Delivery: It is our philosophy that as your physicians, we would rather see you in our office for any problems or questions or issues. We have all of your information, lab results, etc. When you go to Labor & Delivery for non-emergent issues (i.e. - a vaginal discharge, trouble sleeping, lower back pain), it often time takes several hours to be seen and evaluated. Often, the midwife orders extra tests that we would not necessarily do in the office but because she doesn't have all the information we have when we see you). We frequently hear, "Oh my gosh, the speculum they used in L&D was HUGE. It hurt so bad". We have much smaller equipment in our office and the exam is usually much more comfortable. If you are having an issue, don't wait to contact us. The only option may be to go to the hospital. On the other hand, we frequently get

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calls Friday evening, saying, "I've been having this issue for several days..." As a reminder, if you had called earlier in the week, we could have seen you in the office and taken care of things. Finally, insurances may not cover non-emergent visits to the hospital, so please contact our office with questions, concerns and non-emergency related issues.

When to go to Labor & Delivery: If you are more than 35 weeks, you are waiting for painful contractions (can't walk or talk through them) consistently every 4 to 5 minutes for a good hour. Often contractions will come for a few hours and stop. This can happen several times, especially with the first baby. Most first-time moms are shocked at how uncomfortable real labor is. They will frequently make several trips to L&D only to be sent home. This can be frustrating for you and your family.

We try to have you only make one trip to L&D - when you are in real labor. So, if your contractions are consistently every 4 - 5 minutes and painful and you have to stop talking or walking during one and they last 45 to 60 seconds for more than 1 hour, it may be real labor. If you want an epidural, by going to the hospital when they are 4 to 5 minutes apart, you will, hopefully, be 3 to 4 cm dilated, can get admitted, get an IV going and get your epidural within an hour.

If you want to have your baby without an epidural, you can stay home longer, more like every 2 to 3 minutes apart depending on how far you live from the hospital. The ideal situation would be if you show up 8 to 9 cm dilated and delivery within 1 to 2 hours.

This changes if you are GBS +. This culture is done about 34 to 36 weeks and if screening for a particular bacteria that can potentially cause an infection in the baby. If you are positive (and we should tell you the week after the culture is done), then you need to come to the hospital earlier. We want to get 2 doses of IV antibiotics - given 4 hours apart - prior to your delivery. So, epidural or not, when the contractions are 4 to 5 minutes apart and you can't walk or talk during them for an hour OR if your water breaks - with or without contractions - please head to L&D on nights or weekends, or call the office for us to see you if you are GBS+.

If your GBS culture is negative and your water breaks, you can stay at home as long as the amniotic fluid is clear (NOT bloody or green - meconium - a sign the baby may be stressed) for up to 6 to 8 hours. By then, if you have not started contracting, we want to evaluate you to make sure your water really did break and consider some options to help get labor started. If you have started contracting after your water breaks, you can wait for them to get closer and more painful. If you are not in good labor within 8 - 12 hours of breaking your water, please head in to be evaluated - either to our office or Labor & Delivery. Your risk of infection starts to increase once your water has broken.

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Sometimes, it is obvious your water broke - gushing water soaking your clothes, running down your legs. Other times it's not so obvious - your underwear feels really wet - "Did I pee myself?" so you change it and 10 minutes later it's wet again. We can't tell over the phone if it is really broken so again - call the office if it's during the week but nights and weekends - head to L&D. Remember, amniotic fluid is just baby pee. It is yellow (like your own urine) but is like water, i.e., it's not thick like discharge. It may have flecks of white (vernix) in it.

If you are contracting before your water breaks, the contractions will frequently get much stronger after your water breaks. That is one way we have to help with labor if it has slowed down, we break your water.

We often say if you are not sure if you are in labor, you probably aren't. But, you can call us anytime and we can help you decide if it's time to head to the hospital. Often, we can tell by your voice (especially during a contraction) if it's time to head to the hospital. This is why we want to speak you you, not the person with you.

If you need to reach us in an emergency, call the Mercy operator (410) 332-9000 after office hours or on weekends. They will page the doctor on call.

When labor starts, please refrain from heavy, fatty foods that are hard to digest. During labor, blood flow is directed to your uterus and away from your stomach. Therefore, any food that is in your stomach will remain there for many, many hours and may even come back up during the pushing part of labor. So, please stick to easy-to-digest-foods and liquids. Once you are admitted to Labor and Delivery, you can have clear liquids (water, apple juice, Gatorade, frozen pops, etc). Those are usually on hand in Labor and Delivery, but you can bring your own food if, you would like. If you are really in labor, you won't be hungry but you will be thirsty.

Pain management during labor: You should consider what you would like for pain management. If you are going to go "all natural" without any pain medication, consider taking a childbirth class. Consider writing up a birth plan ("birth wishes"). We are happy to accommodate your wishes regarding intermittent monitoring and moving around during labor as long as baby looks fine on the monitor. You always have the option of an epidural. An epidural is a catheter placed in your lower back that delivers continuous pain medication. The medication does not get to the baby or affect the baby in any way. The medication lasts through delivery and any repair that is necessary. Mercy has an anesthesiologist dedicated to Labor and Delivery available 24-hours a day, so the epidural always is available. There might be a wait if the anesthesiologist is in a C-section, so don't wait until you cannot take the pain to ask for an epidural. Once you ask for an epidural, it takes about 25 minutes to get enough IV fluids in so that you can get the epidural. It is only "too late" for an epidural when the baby's head is out, so it is fine to wait and see how it goes.

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If you are in the early stages of labor (less than 3 cm) you may want to consider IV pain medication. It may be a long time until the baby comes and some women don't like being in the bed that long without control of their legs. The pain medication does not take the pain away completely, but does take the edge off and often helps you sleep. We cannot give you IV medication close to delivery because it does make the baby sleepy and can interfere with baby's breathing after birth.

Episiotomy: We rarely do episiotomies (less than 1% of deliveries). We feel that, in general, you will tear less than we would cut. We will massage your perineum (the area between your vagina and anus) to stretch while you are pushing. This can reduce tearing. Having said that, every now and then, an episiotomy is needed and we do our best to protect the area to prevent an extension of that cut. Just to let you know, perineal massage before labor has not been shown to decrease tearing or the need for episiotomies. We do not believe you can massage that area as firmly as we do during labor which is why it doesn't work. As bad as an episiotomy sounds, there are times when it is better than tearing (i.e. if your labia or clitoral hood are tearing OR you are tearing in multiple areas at once).

Lacerations: When we do not perform an episiotomy, you can have a tear or laceration. Usually, these are small and easily repaired. Occasionally, they can be quite large and extensive and require quite some time to repair. If you have an epidural, that will be quite helpful in managing the discomfort during the repair. If you did not get an epidural, we use a local anesthetic to numb the area as best we can but it can still be uncomfortable. The sutures that we use will dissolve. You will not need to return to the office to have them removed. You may start to see small bits of suture (usually purple) starting days to weeks after your delivery.

Delivery of placenta: After the baby is born, we will give you pitocin in your IV or as an intramuscular injection to get your uterus to contract. Without pitocin, substantial bleeding can occur that requires significant intervention on our part. Frequently, the placenta will come out on its own within minutes of the delivery. We examine it to make sure that "all of it" has come out. If it does not come out, we may need to go in after it using our hands (called a manual extraction) or, in the worst case, a D&C is needed to get the placenta out. Both of these are unusual and we only do this if nothing else works. After the placenta is out, the uterus needs to contract to 1/2 its pregnancy size to prevent significant bleeding. Frequently, we will check to make sure the entire placenta is out. The pitocin helps the uterus stay contracted down. Breastfeeding helps the uterus stay contracted down but is not very effective immediately after delivery.

Breech babies: If we find that your baby is breech (butt down instead of its head) at 37 weeks, we can offer to try and turn the baby. It's called an External Cephalic Version (ECV). We schedule it in L&D and you cannot eat for 8 hours prior to the procedure. An ultrasound is done to confirm the baby is breech, blood work is drawn (but not

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sent) and a heplock is placed and you are placed on the monitor. We are making sure the baby's heart rate looks good before we attempt the version. You may be given terbutaline if contractions are seen (to stop them). When we do a version, it can feel like a lot of pressure and discomfort but it should not be terribly painful. If it's too uncomfortable, we stop. We will intermittently check the baby's heart rate to make sure it is tolerating the procedure well. f the procedure is successful, we will place a binder on your abdomen to help keep the baby in the right position and monitor you for another hour or two. If the procedure doesn't work, we will still monitor you to make sure the baby is fine.

There are risks with any procedure. For a version, this includes pain, contractions, bleeding and possibly a C-section if the baby does not tolerate the procedure (which is incredibly rare). If we don't try the version and the baby stays breech, it will mean a C-section in labor. We prefer that the C-section is not scheduled before 40 weeks. This gives the baby every opportunity to turn and going into labor tells us the baby is ready to be born. In the past, we have scheduled C-sections for breech as early as 39 weeks but we have found that in the absence of labor, the baby could end up in the NICU with breathing or eating issues, sometimes for several days. We would rather avoid any NICU stays so waiting the extra time is a good idea. We will be happy to discuss this further in the office if it applies to your pregnancy.

C-section: You may have heard about primary elective C-sections. That means you request to have one. There is no medical reason other than you would like one. It is our policy in this practice to not perform C-sections under those conditions. We believe that a C-section should be considered major surgery and carries much greater risk and, therefore, should not be undertaken without a maternal or fetal indication. If that is something you wish to have, we would suggest you look for a different practice as we won't be able to accommodate your request.

We are often asked, "When will I know if I will need a C-section?" and the answer is: "when the baby is out." We do C-sections only when indicated: if the baby is breech (rear end down) when you're in labor, if the baby is too big for your pelvis, if there is a problem with the baby's heart rate, if you don't dilate once we have you in adequate labor or if the mom is too sick to tolerate labor. We generally can't tell if the baby will be too big for you until you're in labor, sometime surprisingly small women can deliver 8 or 9 or even 10 pound babies vaginally! And we won't know if there will be problems with the heart rate until you're in labor.

In general, 25% of all pregnancies will be C-sections. In our practice, our primary C-Section rate is about than 20%. While no one likes a C-Section, the most important thing is that you and your baby are healthy. Having one C-section does not commit you to having all future deliveries that way (most of the time). We frequently do a trial of labor after a C-section (called TOLAC) which then becomes a VBAC (vaginal birth after C-section) once it's successful. Laboring after a C-section is usually fine but we need to check the operative note from the prior C-section to make sure there are no contraindications to labor.

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Breastfeeding: You will need to decide if you want to breastfeed or bottle feed. Breast milk is the best food for babies and we strongly recommend it. If you are interested in breastfeeding, Mercy has a breastfeeding class that you may find very helpful. There are lactation consultants at the hospital every day to help you with feeding your baby and the nurses are very helpful. They also have been trained to help you learn to breastfeed.

If you are going to breastfeed, try to get the baby on the breast within the first hour or two after birth. Sometimes women want to put the baby to breast immediately after birth. Please don't be disappointed if the baby does not latch on right away and feed. Remember, labor and delivery is hard on the baby as well as the mom. And sometimes, babies need a little time to recover before feeding. Also, your baby has never had to suckle before. While it may be a natural reflex, it is not always effective and often requires time and attention to get it going.

Please keep this in mind: Breastfeeding is very hard the first few days BUT after those first few days, it is SO much easier than bottle feeding. We are telling you this not to scare you but so that you won't think you're doing something wrong because it is so hard. It's kind of like riding a bike - nobody gets up on that bike the first time and takes off. So, please don't give up when it isn't happening easily. Remember, the baby has never had to eat - it's gotten all of it's nutrition through the umbilical cord so it has to learn what to do.

We do recommend a breast pump. There are several different kinds at several different cost levels. Sometimes, it may be easier to rent a pump rather than buy one though you can frequently borrow one from a family member or buy them used. You must get new attachments to go with the pump; those can't be shared. After breastfeeding for a week or two, you could start to pump (after feeding the baby) and collect some extra milk that your partner could bottle feed to the baby. If you could get them to do the 3 am feeding (and let you sleep 4 or 5 hours in a row) that would be even better. Insurance companies now cover breast pumps. Please ask for a prescription for a breast pump and contact your insurance company on the best way for you to get the breast pump they cover. Pacifiers had been thought to possibly interfere with breastfeeding but more recent studies show they can reduce the risk of SIDS so you may want to consider using one. There are many different types (different nipple shapes, glow in the dark, etc.), so choose the one that fits your and baby's needs.

Paperwork: Please complete your portion of paperwork related to maternity leave with the front desk staff. It generally takes a week to complete paperwork. We can fax the completed paperwork to the necessary office so you can pick it up the following week in the office. Please do not ask the on-call doctor to complete the paperwork when you are in the hospital. We do not have the necessary diagnosis codes to appropriately fill out the forms. The same applies to paperwork related to being taken out early (ie. for preterm labor).

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Pediatrician: You need to identify a pediatrician before you deliver. The pediatrician does not have to have privileges at Mercy. If they do, they may come to the hospital to check the baby after delivery. If they don't have privileges, Mercy's pediatric nurse practitioners will check out your baby and send a very complete printout to your baby's doctor. You will need to schedule that appointment before you leave the hospital, so make sure you have a pediatrician's name and phone number with you when you go to the hospital. After you have delivered and been discharged from the hospital, if you have any questions regarding your baby, you need to call your pediatrician, not Hoffman and Associates. We do not take care of the baby after you have delivered.

Circumcision: If you are having a boy you will need to decide whether or not to have him circumcised. Although this was routinely done in the past, it is now considered a cosmetic procedure and is not routinely recommended. It is your choice about whether or not to have it done. If you choose to do a circumcision, one of our doctors will perform the procedure the day after delivery. We do not allow parents to watch the procedure, as it is a medical procedure and does involve crying, cutting and blood loss.

Please keep in mind, there is not a dotted line on your baby's penis to tell us the exact spot to cut. We do our best but would rather err on the side of removing too little skin than too much skin. A boy's penis will have a growth spurt with adolescence and will need the skin that seemed extra when he was a baby. If too much is removed, it can result in scarring and disfigurement with curvature with erections as an adult.

If you know you are having a boy, please request our circumcision handout ahead of time. It goes into greater explanation regarding the procedure and how to care for your baby afterwards. That way, you can make an informed, intelligent decision regarding having your son circumcised.

Cord blood banking: The baby's cord blood can be saved and used to treat many medical problems. You can privately bank the cord blood for your family's use, or donate it for someone else's use. Ask your doctor for complete information on participating in this program. We are not recommending private banking but we encourage everyone to register for public banking. You must register by 34 weeks online to be a donor. We realize it takes a bit of time to fill out the paperwork, but remember, it can save someone's life, maybe another one of your children. Please bring your donation box with you when you go to the hospital in labor.

If you go past your due date: If you have passed your due date and have not gone into labor, don't give up hope! Many women go into labor the week after their due date. We will not let you go more than 2 weeks after your due date, because the risks to the baby increase. We do like first-time moms to go at least a week past their due date before inducing labor, as the risk of C-section increases with induction. If you do pass your due-date, we like to do ultrasounds to make

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sure it is safe to wait. It's called a BioPhysical Profile (BPP), and it's performed at the Center for Advanced Fetal Care (CAFC) starting 3 or 5 days after your due date. The CAFC staff put the monitors on your belly and watches the baby's heart rate for 20 or 30 minutes and look for contractions. Then, they will check the amniotic fluid, check the baby's movements and check to see that the baby is practicing its breathing. If all looks well, it is safe to wait. If the fluid is low or something else doesn't look right, we would induce your labor at that time.

The reason we try to avoid inductions is that it adds hours and hours to your labor time and can increase your risk of a C-section. In general, spontaneous labor for a first time mom will take 12 to 18 hours, on average. Inducing labor can add 6 to 12 hours or more to that time. That's a long time to be hooked up to a monitor and drinking clear liquids. Having said that, 42 weeks is a good reason to be induced. The placenta is aging, which decreases the baby's ability to tolerate the stress of labor and the baby is more likely to have problems with low fluid or meconium after 42 weeks.

Inductions: If you are going to be scheduled for a labor induction, there is usually some flexibility in the day that is chosen. We may ask you if you have a day you prefer or a doctor you prefer and then try to accommodate your requests. When you are set up for an induction, there is an information sheet that must be completed and signed by you and one of the doctors. You must bring a copy of the "induction ticket" to the hospital at the scheduled time. If you forget it and our copy isn't there, the induction may be rescheduled so please don't forget that ticket. Please keep in mind, those scheduled for elective inductions or C-sections (i.e. because you're a week overdue or other such reasons) could be called and rescheduled or cancelled if there are no beds. Sometimes, Labor & Delivery can get so busy that there are no beds (seriously no beds). It is not safe to bring you in when there are no beds available (Laboring in triage or the hallway is not fun) and the staff is stretched so thin. We realize you have planned to come in and may have made childcare arrangements, etc. but sometimes it just gets so busy that we have to reschedule things. We ask your understanding and will do our best to get you in as soon as it is safe. Calling every hour to see if there is a bed available or showing up anyway doesn't get you in any sooner. It just frustrates you and stresses the staff. Some patients have actually thought that there should be an empty room waiting for them if they have been scheduled to come in. It's not like in a hotel where having a reservation guarantees you a room.

Hospital visitation policy: You are allowed 5 visitors at any time. This includes the father of the baby but not a doula. Additional visitors will need to wait in the main lobby of the hospital and take turns.ALL VISITORS (THERE ARE NO EXCEPTIONS) MUST HAVE PICTURE ID. This can be a driver's license or school/college ID/work ID. They must leave the ID at the front desk while they are visiting. If they are unable or unwilling to do this, they will not be able to come up to the 8th or 10th floors. There are NO exceptions. Even if it's the father of the baby or your mother or visitors from out of town, they must provide proper identification. If they do not have a picture ID, they will have to stay in the lobby. If you have a lot of people who plan to come, suggest that they wait to come to the hospital until you are close to delivery (8 or 9 cm)

continued >

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Getting Ready for Labor *continued*

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because the lobby might not be very comfortable for a long wait. Visiting hours on Labor and Delivery are 24-hours a day. Visiting hours on the Mother Baby unit (postpartum) are 8:30am until 8:30pm. Children under 13 are allowed only if they are a brother or sister of the baby (not your brother or sister or the father of the baby's brother or sister). There are no exceptions.

If any of your visitors are sick - a fever, a bad cough or cold - please ask them not to come. The last thing you or your baby needs is to be exposed to germs. If you are going to have other children under the age of 18 in the labor room, you should have a second adult present to watch them, especially if an emergency develops. In other words, if it's just your partner and your other children and you need a C-section, your partner will have to stay with the children and will not be able to go with you for the C-section (your children can not be left unattended in the hospital at any time). Your children cannot be left alone with you when you are admitted to the hospital as a patient even after you deliver. There must always be another adult present. If there is no adult, social services will be contacted to take the children away. This is for your safety and the safety of underage children.

Videography/Photography: Mercy Medical Center has a policy of no videotaping/photographing during the actual delivery process. Video and still pictures are fine after the baby has been born. If someone is seen taking video or photographs during the delivery, they will be made to leave immediately. Please make this clear to all members of your party. If they are told ahead of time, it makes our jobs much easier. They won't be happy if they have to leave before the baby is born because they are taking pictures or video (even with their phones). This policy is true for all hospitals.

Pregnancy paperwork: Most women will have some type of paperwork that needs to be completed during the pregnancy or after delivery. We ask you bring that to our office with the portions that you are responsible for completed. Please know where it needs to be faxed or mailed and have that clearly marked. This paperwork cannot be completed by the doctor who delivered your baby nor the one that sees you prior to being discharged from the hospital. In addition, please do not give the paperwork to the doctor to take to the office. We do a 24 hour shift and are off the next day so it may not make it to the office. We recognize how important getting this paperwork completed is so we ask you to bring it to the office.

Suggestions: If you have suggestions for other topics we should include in this document, please let us know. We hope to provide you with as much information as possible so you can be an informed and knowledgeable partner in our health care relationship. The more information you have, the better your decisions will be.

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