Care Plan: For Transgender Birthing Patients

Chosen Name: _____ ***To Be Used in Hospital***

Name Shown on Care Card: _____

Pronouns: _____

DOB: _____ G____ P____

EDD: _____ Legal Sex on Care Card: M F X

Names and pronouns of family members/support people:

_____

_____

_____

GENDER IDENTITY:

_____

GENDER AFFIRMING CARE (if applicable):

- Hormone therapy:_____
- Surgeries:_____
- Other _____

CURRENT MEDICATIONS:

- _____
- _____
- _____
-

ALLERGIES: _____

Care Preferences:

CONFIDENTIAL Care Plan

Goal	Intervention	Who is involved
Care Team	• GP _____ • Midwife _____ • OB _____ • Doula _____ • Other _____	Triage Nurse Charge Nurse Primary Provider
Labour Support	• Patient's partner(s) • Doula • Family / Friend • Other _____	Primary RN Primary Provider
Pain Relief	• Plans none • Plans Entonox • Plans narcotics • Plans Epidural • Other _____	Primary Provider Primary RN Anesthesia
Delivery	• Plans natural birth • Plans elective CS	Primary Provider Consultant OB Primary RN
In case of C/S	• Regional anesthesia • Partner/Support person to be present	Anesthesia Consultant OB Primary Provider Primary RN
Newborn Feeding	• Chestfeeding/Breastfeeding • Formula • Donor Milk • Expressed Milk • Partner/Co-parent lactating • Bottle and/or SnS	Primary RN Primary Provider

CONFIDENTIAL Care Plan

Special Concerns or Requests	_____ _____ _____ _____ _____ _____	