Birth Parent Requests Regarding In-Hospital Care

I, _____, am working with Adoption Center of Illinois at

Family Resource Center on a possible adoption plan for my child who is expected to be born_____

		800-676-2229
My ACI @ FRC Contact Person	Cell Phone Number	Number Where She Can Be Paged

At the time of delivery I wish to:	Yes	No	Unsure
know the sex of my child	☐	☐	☐
see my child in the delivery room	☐	☐	☐
hold my child in the delivery room	☐	☐	☐

have the following person(s) accompany me through labor and delivery:

Their relationship to me is:

After assignment to my room, if possible I wish to:

be moved off the maternity floor	☐	☐	☐
be in a room by myself	☐	☐	☐
view my child through the nursery window	☐	☐	☐
hold my child	☐	☐	☐
care for my child	☐	☐	☐
have the potential adoptive parents see my child in my presence	☐	☐	☐
have the potential adoptive parents care for my child in my presence	☐	☐	☐
have the potential adoptive parents see my child without me present	☐	☐	☐
have the potential adoptive parents care for my child without me present	☐	☐	☐
I have been informed that I may change my mind about these requests at any time and in order to do so, I should notify my nurse and/or the hospital social worker.	☐	☐	☐

I understand that I may determine who may or may not visit me in the hospital.

The following people may visit me:

_____

_____

The following people may NOT visit me:

_____

_____

☐ **I do NOT want any visitors at all.**

I understand that the purpose of this document/form is to clarify my requests regarding my care and the care of my child while we are in the hospital. I have completely read this form and had it explained to me by a representative of Adoption Center of Illinois at Family Resource Center and I understand that I am not obligated or required to complete this form.

_____	_____
Print or Type / Name of Birth Mother	Print or Type / Name of Witness
_____	_____
Signature of Birth Mother	Signature of Witness
Date: _____	Date: _____