Maternity Booking Registration

UR Number:
Surname:
Given Name:
Date of Birth: / / Sex: M / F
(Affix Hospital I.D. Label if Available)

SURNAME: ______ **GIVEN NAME:** ______
PREVIOUS SURNAME: ______
ADDRESS: ______
SUBURB/TOWN: ______ **POST CODE:** ______
TELEPHONE: H: ______ **M:** ______ **BIRTH DATE:** ______
COUNTRY OF BIRTH: ______ IF AUSTRALIA, indicate **STATE:** ______
MARITAL STATUS : Single/ Married/ Defacto **TITLE:** Mrs/ Miss/ Ms ______

I have previously been an inpatient **of Angliss Hospital:** Yes ☐ No ☐ Which Year? ______
I have previously been an inpatient **of Box Hill Hospital:** Yes ☐ No ☐ Which Year? ______
I am of Aboriginal Descent: Yes ☐ No ☐ I am of Torres Strait Islander Descent: Yes ☐ No ☐

PREFERRED LANGUAGE ______ **INTERPRETER REQUIRED:** Yes ☐ No ☐

FIRST CONTACT PERSON:
FULL NAME: ______ **RELATIONSHIP:** ______
ADDRESS: ______
SUBURB/TOWN: ______ POST CODE: ______
TELEPHONE: H: ______ M: ______ Mobile: ______

FIRST CONTACT PERSON:
FULL NAME: ______ **RELATIONSHIP:** ______
ADDRESS: ______
SUBURB/TOWN: ______ POST CODE: ______
TELEPHONE: H: ______ M: ______ Mobile: ______

Medicare Card No: _ _ _ _ _ _ _ _ _ _ _ What number are you on the card? ____
Expiry Date: ______

Concession Card (if applicable) _ _ _ _ _ _ _ _ _ _ _ Expiry Date: ______
Do you have Private Health Insurance: Yes ☐ No ☐ Name of Health Fund: ______

FAMILY DOCTOR'S DETAILS: (Please state your usual General Practitioner)
NAME: ______ TELEPHONE NO: ______
ADDRESS: ______ POST CODE: ______

I INTEND TO BIRTH AT: ______

ANGLISS HOSPITAL
MODEL OF CARE: (please tick)
- ☐ Obstetrician Dr: ....
- ☐ GP Obstetrician: Dr ....
- ☐ Family Birth Centre
- ☐ Partnership Maternity Care
- ☐ Yarra Ranges Health

BIRRALEE MATERNITY SERVICE
MODEL OF CARE (please tick)
- ☐ GP Shared Care
- ☐ Midwife Shared Care
- ☐ Know Your Midwife
- ☐ WINGS
- ☐ Private Obstetrician: Dr ....
- ☐ Yarra Ranges Health

I understand that the Hospital may exchange details of my (the patient) care and treatment with my nominated General Practitioner and/or specialist Doctor or other Professional Healthcare Providers unless I notify the hospital in writing that I do not wish this to take place.

Signed: ______ Date: ______

FSG Print Management Tel: 9873 5144 Fax: 9873 5966

MATERNITY BOOKING REGISTRATION EH 323000

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Given Name:

Date of Birth: / / Sex: M / F

(Affix Hospital I.D. Label if Available)

Date of last period: ________ **Length of cycle:** ____ days **Booking Weight:** _____ kg. **Height:** ____cm
Number of pregnancies: _______ **Number of births** (over 20 weeks) ___________

EDB: Menstrual: __________________ Ultrasound: ______________________

Has your GP ordered- **Antenatal blood tests**: Yes/No **Ultrasound**: Yes/No **Combined Screening**: Yes/No

HEALTH QUESTIONS	Tick if YES		Tick if YES
***Are you over 38 years of age?**		Do you have thyroid problems?	
***Are you currently under specialist care for medical problems? Are you having treatment or medication for this condition?**		Have you had more than 5 babies?	
***Do you have any concerns with congenital or hereditary disorders?**		Have you had fits in pregnancy or labour?	
***Does your referring doctor consider an early appointment desirable?**		Were there complications with other babies because you have a negative blood group?	
***Have you had 3 or more miscarriages?**		Have you had a caesarean section?	
***Do you have known cervical incompetence?**		Have you had a previous small baby less than 2500g?	
***Have you previously lost a baby during pregnancy or shortly after birth?**		Have you had a previous large baby weighing more than 4500g?	
***Are you having twins or triplets?**		Have you had a post partum haemorrhage requiring transfusion?	
Have you had any anaesthetic difficulties excluding vomiting?		Have you had any other significant pregnancy or birth problems?	
Have you needed hospital treatment for asthma in the 12 months?		Have you had reconstructive surgery to your pelvic floor?	
Do you have blood problems such as low blood count or clots in the legs (DVT)?		Are you currently taking any drugs of addiction (illicit drugs/ methadone/ buprenorphine/ excessive alcohol intake)?	
Have you required medication for epilepsy in the last 12 months?		Do you have a mental health problem eg depression or past history of postnatal depression?	
Do you have a heart condition requiring specialist care or a past history of heart surgery?		Are you under 20 years of age?	
Do you have high blood pressure?		Does anyone in your household have problems with anger/aggression?	
Do you have diabetes? Do you require insulin?		Would you like to talk to a Social Worker?	

Please list all previous pregnancies (including miscarriages and terminations).

Date	Weeks	Hospital	Type of birth	Pregnancy, labour & birth problems	Sex M/F	Birth weight	Baby problems Type of feeding (breast/bottle)

MATERNITY BOOKING REGISTRATION

Revised October 2008