

**Community Midwifery Program**

**APPLICATION FORM**

All information, including the **PATIENT REGISTRATION FORM must** be completed for your application to be assessed

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Date of Application** | | | | | | |  | | | | | | | | | | | | | URMN (if known) | | | | | | |  | | | | | |
| Given Name | | | |  | | | | | | | Surname as on Medicare Card | | | | | | | | | | | | |  | | | | | | | | |
| Maiden Name | | | | |  | | | | | | | | | | | Father’s/Partners Name | | | | | | | | | | |  | | | | | |
| Residential Address | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | |
| Suburb | | |  | | | | | | | | | | | | | | | | | | Postcode | | | | |  | | | | | | |
| Telephone | | Mobile | | | |  | | | | | | | | Home | | | | | | |  | | | | | | | | Work | |  | |
| Email |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Applicant’s date of birth | | | | | | | | |  | | | | | | | | | Age | | | | |  | | | | | | | | | |
| Medicare Number | | | | | |  | | | | | | | | | Reference Number | | | | | | | | | |  | | | Expiry Date | | | |  |
| Pre-pregnancy weight | | | | | | | | | |  | | | Height | | | |  | | | | | BMI **(office use only)** | | | | | | | |  | | |
| Do you require an interpreter? | | | | | | | | | |  | | | If so, please give details  (i.e. limited mobility, hearing deficit) | | | | | | | | | | | | | |  | | | | | |
| Do you have special needs? | | | | | | | | | |  | | |
| Do you have a carer? | | | | | | |  | | | | | Name of carer | | | | | | |  | | | | | | | | | | | | | |

**CLIENT DETAILS**

**YOUR DOCTOR (Please give FULL name and address)**

|  |  |  |  |
| --- | --- | --- | --- |
| Doctor & Practice Name |  | | |
| Address |  | | |
| Postcode |  | Phone |  |

**THIS PREGNANCY**

Preferred place of birth **(please select ONE only)**

|  |  |  |
| --- | --- | --- |
| Home □ | Kalamunda □ | KEMH - Family Birth Centre (FBC) □  \*Please see note below |
| |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | Expected Date of Birth | |  | How many babies have you birthed? | | | |  | Previous  **CMP** Client? | | **Yes □ Year\_\_\_\_\_\_**  **No □** | | Do you have any current illnesses or medical problems **OR** have you had any problems with previous pregnancies or births?  ***i.e. heavy bleeding, caesarean, high blood pressure, diabetes*** | | | | | |  | | | | | | If yes, please give details or contact the Midwifery Manager at [cmp.wchs@health.wa.gov.au](mailto:cmp.wchs@health.wa.gov.au) | | | | | | | | | | | | **“I confirm that I will comply with the CMP minimum standards of screening tests in pregnancy to include an ultrasound scan and a**  **blood test to check my iron levels and blood group”**  **Yes** **□ No** **□**  In an emergency, would you accept a blood transfusion? **Yes** **□ No** **□**  Are you currently taking any medication? **Ye**s **□** **No** **□** if yes, give details  Current Medication if applicable: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **KEMH-FBC** - I am aware that my referral may be directed to CMP based on my post code **Ye**s **□** **No** **□** | | | | | | | | | | | | **If you are planning to birth at the Family Birth Centre, King Edward Memorial Hospital or at home using KEMH as**  **your supporting hospital, please read the following important information below:**  *Did you know that you can use your private health insurance* ***(Maternity cover required)*** *at King Edward Memorial*  *Hospital (KEMH)/Family Birth Centre with no out-of-pocket expenses, and it greatly assists our hospital too?*  *Opting to use your Maternity private health insurance helps make your stay with us a little more comfortable, and also directly helps our hospital. If you would like to use your* ***Maternity Private Health insurance*** *on your admission please complete the details below:* | | | | | | | | | | | | Health Fund Name |  | | | Health Fund Level |  | | Membership No | |  | |   Please note your application will be assessed based on our postcode catchment and should you reside inside the KEMH - FBC catchment your referral may be referred directly to them for allocation to birth at the FBC. | | |

Please fax, email or post your completed application form to CMP Administration:

**Mail**: Internal Box 86, Lakeside Shopping Centre, 420 Joondalup Drive, Joondalup WA 6027

**Email**: [cmp.wchs@health.wa.gov.au](mailto:cmp.wchs@health.wa.gov.au)

**Fax**: 9301 9218

By submitting this application you give your consent to the Community Midwifery Program sharing your medical records with other Health Professionals involved in your care and in case of emergency, you authorise any member of the CMP to take all appropriate measures to support your antenatal, birth and postnatal care. All information will be treated as strictly confidential.

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