|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Received** | **Entered** | **Allocated/**  **Declined** | **Manager Initials** | **Midwife** | **Midwife Informed** | **UMRN** | **Client Email** |
|  |  |  |  |  |  |  |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Surname |  | | | | Given Name | | | |  | | | | | Maiden Name | | | | | |  | | |
| Home Address | | |  | | | | | | | | | | | | | | | | | | | |
| Suburb |  | | | | | | | | | | | | | | | | | | Postcode | | |  |
| Postal Address | | |  | | | | | | | | | | | | | | | | | | | |
| Phone | Mobile | | |  | | | | Home | | |  | | | | | Work | |  | | | | |
| Email |  | | | | | | | | | | | | | | | | | | | | | |
| Applicants Date of Birth | | | | |  | | | | | | | | Age | | | |  | | | | | |
| Medicare Number | | | | |  | | | | | | | | Marital Status | | | |  | | | | | |
| Pre-Pregnancy Weight | | | | |  | | Height | | |  | | | | | BMI **(office use only)** | | | | | |  | |
| Do you have any special needs? | | | | | |  | | | If so, please give details:  i.e. limited mobility, hearing deficit | | | | | | | |  | | | | | |
| Interpreter Required? | | | | | |  | | |
| Do you have a carer? | | | | |  | | | | Name of Carer | | | |  | | | | | | | | | |
| Next of Kin | |  | | | | | | | | | | Country of Birth | | | | |  | | | | | |

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

|  |  |
| --- | --- |
| Name |  |
| Address |  |
| Postcode  **THIS PREGNANCY** |  |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Expected Date of Birth |  | How many babies have you birthed? | |  | | Previous FBC Client? | | | **Yes**  **No** |
| Do you have any current illnesses or medical problems? (e.g.: Diabetes, blood pressure problems, asthma, heart problems, anxiety/depression etc?)  **Yes** **No** | | | | | | | | | |
| If **yes**, please give details | | | | | | | | | |
| Have you had any problems with previous pregnancies or births? (e.g. Caesarean Section, Gestational Diabetes, Pre-eclampsia, heavy blood loss after birth, retained placenta, shoulder dystocia, miscarriages etc?)  **Yes** **No** | | | | | | | | | |
| If **yes**, please give details | | | | | | | | | |
| Are you currently taking any medication?  If **yes**, please give details: | | | | | **Yes** | | | **No** | |
| **I confirm that I will comply with the FBC minimum standards as below:** | | | | | | | | | |
| Oral Glucose Tolerance Test (26-28 Weeks) | | | | | | | **Yes No** | | |
| Anatomy Scan at 20 weeks | | | | | | | **Yes No** | | |
| In an emergency, would you accept a blood transfusion? | | | | | | | **Yes No** | | |
| I am aware that FBC does not offer epidural analgesia and that discharge is expected 4 hours after birth | | | | | | | | **Yes** | |
| **I am aware that my referral may be directed to CMP based on my postcode** | | | | | | | | **Yes** | |
|  | | | **Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | |