Maternity Registration Form

Women's and Children's Services

Western Health

IMPORTANT INFORMATION – Please Read Carefully

Please complete the Registration Form and forward to the Maternity Unit Booking office.

Estimated Date of Birth: / / Hospital UR No:

Referring Doctor: Date of Referral: / /

Referral Letter Attached: Yes ☐ No ☐ ***Note: A GP referral letter is required for all Gynaecology appointments.***

Have you previously been a patient at Sunshine Hospital? Yes ☐ No ☐ Dates:

Patient Details

Title: Mrs ☐ Miss ☐ Ms ☐ Other: Marital Status:

Surname: Given Name(s):

Previous name:

Date of Birth: / / Country of Birth:

Address:

Suburb: State: Post Code:

Telephone Home: Work: Mobile:

Email: Are you Aboriginal or Torres Strait Islander? Yes ☐ No ☐

Language: Religion:

Interpreter Required? Yes ☐ No ☐

Occupation:

Person to contact in case of Emergency / Next of Kin

Title: Mr ☐ Mrs ☐ Other: ☐ Relationship:

Surname: Given Name(s):

Address:

Suburb: State: Post Code:

Telephone Home: Work: Mobile:

Medicare and Insurance Details

Medicare Number: Number next to Name on Medicare Card:

Medicare Card Expiry Date: / / Do you have Private Health Insurance? Yes ☐ No ☐

Name of Fund:

Membership Number: Overseas Visitor / Student? Yes ☐ No ☐

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Past Medical History

Anaemia	Yes ☐	No ☐	Arthritis	Yes ☐	No ☐
Asthma / Bronchitis	Yes ☐	No ☐	Back / Spinal Problems	Yes ☐	No ☐
Bleeding Disorder	Yes ☐	No ☐	Blood Cot	Yes ☐	No ☐
Epilepsy / Fits	Yes ☐	No ☐	Hearing Impairment	Yes ☐	No ☐
Heart Disease	Yes ☐	No ☐	Hepatitis	Yes ☐	No ☐
High/Low Blood Pressure	Yes ☐	No ☐	Infectious Disease	Yes ☐	No ☐
IVF Pregnancy	Yes ☐	No ☐	Kidney Disease	Yes ☐	No ☐
Mastitis	Yes ☐	No ☐	Mental Illness / Anxiety Attacks	Yes ☐	No ☐
Multiple Pregnancy	Yes ☐	No ☐	Physical Disability	Yes ☐	No ☐
Pelvic Problems	Yes ☐	No ☐	Placenta Praevia	Yes ☐	No ☐
Pneumonia	Yes ☐	No ☐	Antenatal or Postnatal Depression	Yes ☐	No ☐
Pre-Eclampsia	Yes ☐	No ☐	Recent Cortisone Treatment	Yes ☐	No ☐
Rheumatic Fever	Yes ☐	No ☐	Thyroid Problems	Yes ☐	No ☐
Previous Caesarean Birth	Yes ☐	No ☐	Anaesthetic Difficulties	Yes ☐	No ☐
Drug Allergies	Yes ☐	No ☐	Food or other Allergies (eg latex)	Yes ☐	No ☐
Do you drink alcohol	Yes ☐	No ☐	Do you smoke	Yes ☐	No ☐
Drug Use	Yes ☐	No ☐	Severe Medical problem	Yes ☐	No ☐

- (prescribed or unprescribed)

If you answered yes to any medical conditions or if you have any other medical conditions, please give further details:

_____

_____

_____

_____

Please list any Medications either prescribed, herbal or over the counter you are currently taking:

Medication	Dose & Frequency	Medication	Dose & Frequency

Office Use Only

Referral in History:	Yes ☐	No ☐	Shared Care:	Yes ☐	No ☐
Referral with the woman:	Yes ☐	No ☐	Midwifery Group Practice:	Yes ☐	No ☐
Referral in Women's Clinic:	Yes ☐	No ☐			

Obstetrician Booking Apt: / /

1st Midwife Apt: / /

Letter Sent:	Yes ☐	No ☐	OSV Information Letter Sent:	Yes ☐	No ☐
Registered on iPM:	Yes ☐	No ☐	Wait Listed:	Yes ☐	No ☐

Booking Clerk:

Date: / /