|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |