Antenatal Booking Form - Shoalhaven Hospital and Milton Ulladulla Hospital for MAPS, MGP and GP ANSC

Complete and submit to [ISLHD-SHG-MAPS@health.nsw.gov.au](mailto:ISLHD-SHG-MAPS@health.nsw.gov.au)

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| --- | --- |
| Surname: | Click or tap here to enter text. |
| Given Name/s: | Click or tap here to enter text. |
| Previous or maiden name: | Click or tap here to enter text. |
| Date of Birth: | Click or tap to enter a date. |
| Email Address: | Click or tap here to enter text. |
| Last Menstrual Period: | Click or tap here to enter text. |
| Expected Date of Delivery: | Click or tap to enter a date. |
| Current number of weeks pregnant: | Click or tap here to enter text. |
| Marital Status: | Choose an item. |
| Occupation: | Click or tap here to enter text. |
| Religion: | Click or tap here to enter text. |
| Country of Birth: | Click or tap here to enter text. |
| Do you identify as Aboriginal or Torres Strait Islander? | Choose an item. |
| Will your baby identify as Aboriginal or Torres Strait Islander? | Choose an item. |
| If your baby will identify as Aboriginal or Torres Strait Islander would you like care with an Aboriginal health service? | Choose an item. |
| Languages Spoken at Home: | Click or tap here to enter text. |
| Interpreter Needed: | Choose an item. |
| Billing Status: | Choose an item. |
| Medicare Number: | Click or tap here to enter text. |
| Medicare Individual Reference Number: | Click or tap here to enter text. |
| Private health insurance: | Choose an item. |
| Fund Name: | Click or tap here to enter text. |
| Fund Number: | Click or tap here to enter text. |
| **Current Address** | |
| Street: | Click or tap here to enter text. |
| Suburb: | Click or tap here to enter text. |
| State and Postcode: | Click or tap here to enter text. |
| **Contact Numbers** | |
| Mobile: | Click or tap here to enter text. |
| Home: | Click or tap here to enter text. |
| Work: | Click or tap here to enter text. |
| **Emergency Contact** | |
| Contact Name: | Click or tap here to enter text. |
| Contact Relationship: | Click or tap here to enter text. |
| Contact Phone: | Click or tap here to enter text. |
| **GP Details** | |
| GP Name: | Click or tap here to enter text. |
| GP Practice: | Click or tap here to enter text. |
| GP Phone: | Click or tap here to enter text. |
| **Pregnancy Information** | |
| This is baby number: | Click or tap here to enter text. |
| This is pregnancy number: | Click or tap here to enter text. |
| Where did you have the ultrasounds done for your pregnancy? | Choose an item. |
| Ultrasounds - Other: | Click or tap here to enter text. |
| Where did you have the blood tests done for your pregnancy? | Other (enter below) |
| Blood tests - Other: | Click or tap here to enter text. |
| Are you currently pregnant with twins or triplets? | Choose an item. |
| Any previous pregnancy issues? | Click or tap here to enter text. |
| **Medical Information** | |
| Height (cm): |  |
| Weight at beginning of pregnancy (kg): | Click or tap here to enter text. |
| Any past or current medical or mental health issues? | Click or tap here to enter text. |
| What is your preferred Model of Care? | Choose and item. |
| Is there anything else you would like us to know? |  |