# Maternity Booking Form

WOMEN'S HEALTH

Capital & Coast District Health Board
Ōpoko ki te uru hauora

*Surname:* ..... *NHI:* .....
*First Names:* .....
*Date of Birth:* ...../...../..... *Sex:* .....
*PLACE PATIENT ID HERE*

| | | |
|---|---|---|
| LMC: | Other provider: | Contact number: |
| Partner's family name: | Partner's given name: | |
| Intended facility of birth: ☐ WRH ☐ KMU ☐ PMU | Enclosed: | ☐ Care plan |
| Person responsible for booking: | ☐ PIF | ☐ Smoking cessation |
| | ☐ Scan report | ☐ Newborn notification form |
| Booking date: / / | ☐ Violence screening | ☐ Blood results |

## CURRENT PREGNANCY

**Have you been pregnant before?** ☐ No ☐ Yes

**Gravida:**

**Para:**

**Menstrual cycle:**
- ☐ Regular
- ☐ Irregular
- ☐ Primary amenorrhoea
- ☐ Secondary amenorrhoea
- ☐ Unknown

Length: days

**LMP:**
- ☐ Certain
- ☐ Uncertain
- ☐ Not known

Date: / /

**EDD**
EDD by dates : / /
Agreed EDD: / /
Reason:

**Scan (earliest):**
Maturity est:
Date: / /
Fetuses:
Scan EDD: / /

**Fertility treatment**
- ☐ No
- ☐ Does not want to disclose
- ☐ No previous assisted reproduction
- ☐ Clomiphene
- ☐ Gonadotophins
- ☐ IVF (in vitro fertilisation)
- ☐ IVF (natural/unstimulated cycle)
- ☐ AIH/IUI:
- ☐ Other:
- ☐ Unknown
- ☐ GIFT
- ☐ ICSI
- ☐ Donor egg
- ☐ DI egg
- ☐ DI sponsor

**Tests:** Antibody result:

| | | | |
|---|---|---|---|
| ☐ No antibodies present | | ☐ Anti Kell | |
| ☐ Other: | | ☐ Anti D | ☐ Anti C |
| Chlamydia | ☐ Neg | ☐ Pos | ☐ Equivocal |
| Hep B | ☐ Not detected | ☐ Detected | |
| Hep C | ☐ Neg | ☐ Pos | |
| HbA1c | _____ mmol/mol | | |
| HIV | ☐ Not detected | ☐ Detected | |
| Rubella | ☐ Non immune | | ☐ Immune |
| Syphilis EIA | ☐ Nonreactive | | ☐ Reactive |
| MRSA | ☐ Neg | ☐ Pos | ☐ Equivocal |
| GBS | ☐ risk based or | ☐ Neg | ☐ Pos |

**Observations**
Latest Hb _____ BP: Systolic _____
Ferritin _____ Diastolic _____
Height _____ cm Weight _____ kg

**Urine at booking**
Urinalysis ☐ NAD
☐ Abnormal, specify:

## OBSTETRIC HISTORY

| Birth | Pregnancy | Labour & puerperium | Infant | |
|---|---|---|---|---|
| *Date/place* | *Duration (wks), complications* | *Duration (hrs), complications, delivery method* | *Live/SB/NND, sex, B.Weight (g)* | *Breastfeeding (nths), problems* |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

## MATERNAL HISTORY

| Drug/med allergies | Blood: | Transfusions: | ☐ NZ - problem |
|---|---|---|---|
| ☐ Yes, specify: _____ | Group: | ☐ Never | ☐ Abroad - no problems |
| ☐ No | Rhesus: | ☐ Unknown | ☐ Abroad - problem |
| ☐ Unknown | | ☐ NZ - no problems | ☐ Other: |

## PAST MEDICAL HISTORY

| | | | |
|---|---|---|---|
| ☐ Genetic disorder | ☐ Renal/UTI | ☐ Autoimmune | ☐ Bone/joint disorders |
| ☐ Congenital abnormality | ☐ Asthma | ☐ Epilepsy/neurological | ☐ Skin problems |
| ☐ Infections/STI | ☐ Lung disorder/TB | ☐ Gastro-intestinal | ☐ Bleeding/clotting disorder |
| ☐ Cardiac | ☐ Diabetes | ☐ Liver | ☐ Psychiatric/mental illness |
| ☐ Hypertension | ☐ Thyroid | ☐ Incontinence | ☐ Other: |

☐ Please detail any conditions ticked:

**Surgical smears** Last cervical smear, year: Result:

Colposcopy: ☐ No ☐ Yes ☐ Unknown

**Surgical history**

| | | | |
|---|---|---|---|
| 1. | Year | 3. | Year |
| 2. | Year | 4. | Year |

**Anaesthesia** Previous anaesthesia:

☐ Malignant hyperthermia ☐ Other anaesthesia problems:

**Diet** ☐ Conventional ☐ Healthcare prescribed:

☐ Non healthcare prescribed: ☐ Vegetarian

**Current medication** ☐ None ☐ Unknown

Specify: _____

**Smoking status**

Have you ever smoked? ☐ Yes ☐ No ☐ Unknown

Has the patient smoked in the last month? ☐ Yes ☐ No

Cessation advice given? ☐ Yes ☐ No NRT offered? ☐ Yes ☐ No

***Complete Smoking Dependence Assessment & Cessation Referral Form (mandatory)***

**Alcohol** Do you drink alcohol? ☐ Yes ☐ No ☐ Declined to answer

Average weekly consumption (last 12 months): standard drinks per week

**Substances** ☐ Yes ☐ No ☐ Unknown

**Family medical history**

| | | | |
|---|---|---|---|
| ☐ Asthma | ☐ Cancer | ☐ Congenital conditions | ☐ Depression |
| ☐ Diabetes | ☐ Epilepsy | ☐ Genetic counselling | ☐ Haemotological |
| ☐ Hypertension | ☐ Multiple pregnancy | ☐ Family obstetric history | ☐ Psychiatric history |
| ☐ Allergies | ☐ Cleft palate | ☐ Malignant hyperthermia | ☐ Congenital dislocated hips |
| ☐ Deafness | ☐ Heart condition | ☐ Neural tube defect | ☐ Pre-eclampsia |
| ☐ Cerebral palsy | ☐ TB/risk factors | ☐ Others: | |

## ELIGIBILITY FOR FREE MATERNITY SERVICES - *NCC to complete*

| YES | NO | ELIGIBILITY CRITERIA -WOMAN | DOCUMENTATION REQUIRED |
|---|---|---|---|
| ☐ | ☐ | The woman is a NZ citizen or permanent resident | **Copy of passport documentation required** |
| ☐ | ☐ | The woman has a work permit for 2 or more years or has several permits totalling 2 or more years (not a Work Visa) | **Copy of passport documentation required**<br>If mother not eligible – baby may be eligible if partner has a valid Work Permit. |
| ☐ | ☐ | The woman is married to a NZ Citizen or a Permanent Resident | **Copy of partners passport and marriage certificate required** |
| ☐ | ☐ | The woman is in a Defacto Relationship with a NZ Citizen, permanent resident or work permit holder for 2 or more years or has several permits totalling 2 or more years (not a work visa) | **Copy of partners passport and women's to show she is legally in NZ and proof of relationship as per below:**<br>▪ Joint Bank Account statements OR<br>▪ Household bills or Hire Purchases in joint names OR<br>▪ Joint ownership of assets such as a home OR<br>▪ Letter from Immigration Service stating that the ineligible woman has been granted temporary immigration visa or has lodged a residence permit application on the basis of her relationship with a New Zealander |
| ☐ | ☐ | Australian citizen or permanent resident who has resided or intends to reside in NZ for 2 years | **Australian passport and evidence of intention to reside in NZ** |
| ☐ | ☐ | The woman is a UK/Aus/Nth Ireland Citizen or Permanent Resident. South Ireland is not eligible | **Eligible for free care for immediately necessary treatment only** |

**WOMAN ELIGIBLE** ☐ Yes ☐ No Signature: Date:

| YES | NO | ELIGIBILITY CRITERIA - BABY | DOCUMENTATION REQUIRED |
|---|---|---|---|
| ☐ | ☐ | Mother is eligible for free health care | **As above** |
| ☐ | ☐ | Father is eligible for free health care | **Passport evidence of eligibility** |

**BABY ELIGIBLE** ☐ Yes ☐ No Signature: Date: