

Newborn Notification form

Read Newborn Services, Well Child/Tamariki Ora Providers information sheet before completing

PLACE OF BIRTH	<input type="checkbox"/> Wellington Hospital	<input type="checkbox"/> Kenepuru Maternity Unit	<input type="checkbox"/> Paraparaumu Maternity Unit
	<input type="checkbox"/> Hutt Hospital	<input type="checkbox"/> Wairarapa Hospital	<input type="checkbox"/> Te Awakairangi Birthing Centre
			<input type="checkbox"/> Home

BABY'S DETAILS	First name(s):		
Family name:			NHI number:
Date of birth: / /	Sex (at birth):	<input type="checkbox"/> Male	<input type="checkbox"/> Female
		<input type="checkbox"/> Indeterminate	

BABY'S PHYSICAL ADDRESS (where your baby will live)			
Unit/house number:	Street:		
Suburb:	City/town:		

BABY'S POSTAL ADDRESS (where you would like your mail delivered, leave blank if same as above)			
Unit/house number:	Street:		
Suburb:	City/town:		

BABY'S ETHNIC GROUP (please tick all that apply)			
<input type="checkbox"/> New Zealand European	<input type="checkbox"/> Māori	<input type="checkbox"/> Samoan	<input type="checkbox"/> Cook Island Māori
<input type="checkbox"/> Tongan	<input type="checkbox"/> Niuean	<input type="checkbox"/> Chinese	<input type="checkbox"/> Indian
Other such as Dutch, Japanese, Tokelauan. Please state:			

PARENT/GUARDIAN DETAILS	First name(s):		
Family name:			NHI number:
Date of birth: / /	Relationship to baby:		
Daytime number:	Mobile:	Email:	
Do you consent to receive communication from the registered providers:			
via text message?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
via email?		<input type="checkbox"/> Yes	<input type="checkbox"/> No

ALTERNATIVE CONTACT PERSON (preferably not living with baby in case we can't get hold of you e.g. you have moved house)			
First name(s):	Family name:		
Unit/house number:	Street:		
Suburb:	City/town:		
Main contact number:	Relationship to baby:		

BABY INFORMATION			
Baby's general practice is:		Baby's doctor is:	
I require assistance to find a doctor: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Interpreter required? <input type="checkbox"/> No <input type="checkbox"/> Yes <i>specify language here</i>			
Well Child/Tamariki Ora provider chosen: <input type="checkbox"/> Hora Te Pai (Kapiti) <input type="checkbox"/> Maraeroa (Porirua) <input type="checkbox"/> Ora Toa (Porirua & Wellington)			
<input type="checkbox"/> Pacific Health Services (Hutt Valley) <input type="checkbox"/> Te Rūnanganui o Te Āti Awa (Hutt Valley) <input type="checkbox"/> Whaiora (Wairarapa) <input type="checkbox"/> Plunket			
Is your baby likely to require protection from Tuberculosis (TB)? <input type="checkbox"/> Yes <input type="checkbox"/> No			
<i>Your midwife will discuss this with you and refer you to BCG services if needed.</i>			

LEAD MATERNITY CARER	Name:	Ph:
-----------------------------	--------------	------------

We will share the information on this form with the health providers indicated in order to facilitate your baby's enrolment with the newborn services. You do not have to provide the information requested on this form, or enrol your baby with these services. If you would prefer not to provide all or some of the information that we have asked for, please let your midwife/LMC know. They will be able to explain the consequences (if any) of not providing the information. You also have the right to ask for access to your information, and to ask for your information to be corrected if you do not believe it is accurate.

PARENT/GUARDIAN SIGNATURE	Signature:	Date:
----------------------------------	-------------------	--------------