WARKWORTH
BIRTHING CENTRE

BOOKING FORM

Please complete both sides of this form

NHI: _____

Full Name: Mrs/Miss/Ms _____

Preferred Name: _____ **Email address:** _____

Address: _____ **Postcode:** _____

Postal Address (if different from above)**:** _____

Phone Home: _____ **Work:** _____ **Mobile:** _____

D.O.B. _____ **Age:** _____ **Occupation:** _____

Medical Centre /GP: _____ **Ethnic Group:** Mother _____ Baby _____

LMC & Postnatal Midwife: _____

_____

Next of Kin:

Name: _____

_____

Relationship: _____

_____

Phone: _____

Partner or Support Person:

Name: _____

_____

Relationship: _____

_____

Phone: _____

Residency Status:

Country of birth:

Please include a copy of relevant passport page showing residency status if not born in New Zealand.

☐ NZ Citizen ☐ Work Permit

☐ NZ Permanent Resident ☐ Visitor Permit

Hospital charges may apply to Non-Resident mothers and babies

First language _____

Interpreter needed ☐ Yes ☐ No

L.M.P. / / ☐ certain ☐ uncertain

Menstrual Cycle ☐ regular ☐ irregular

E.D.D. / / **Scan E.D.D. Date** / /

Height: **Weight:**

Pre/Early Pregnancy BMI:

Medical and Surgical History

☐ No History

Family History

☐ No History

Blood Group: _____

Antibodies	☐ positive	☐ negative
Hep B	☐ positive	☐ negative
HIV	☐ positive	☐ negative
Rubella	☐ immune	☐ not immune

Previous blood transfusions ☐ yes ☐ no

Gravida

Parity

Current Medications

☐ Folic Acid ☐ Iodine

☐ Iron

Allergies

☐ Nil

Medic Alert ☐ yes ☐ no

Gynae & Obstetric History		Pregnancy		Labour or miscarriage			Infant				
Place of delivery	Date	Duration in weeks	Complications	Duration	Birth Outcome	Postpartum	Sex	Alive NND SB	Birth Weight	Feeding Method	Length of feeding

56 View Rd, Warkworth 0910
Tel: 09 425 8201
Email: admin@wwbc.co.nz
www.warkworthbirthcentre.co.nz

Planned place of birth (please tick one)

- ☐ Warkworth Birth Centre
- ☐ North Shore Hospital
- ☐ National Women's/Auckland City Hospital
- ☐ Waitakere Hospital
- ☐ Whangarei Hospital
- ☐ Home

Smokefree status

- ☐ Never smoked tobacco
- ☐ Ex smoker < 12 months
- ☐ Ex smoker > 12 months
- ☐ **Current smoker - Number . . . .cig/day**
- ☐ Partner Smokefree

Postnatal Care Plans

- ☐ Early discharge - before 12 hrs
- ☐ Full postnatal stay

Postnatal beds are subject to availability on the day for women transferring from another hospital.

Your LMC will arrange your transfer to our Centre.

Any special dietary, religious or cultural requirements (please specify)

- ☆ It is your right to be fully informed and consent to any procedures or tests for you and your baby during your stay at the centre.
- ☆ Please ensure the email address you have given us on this form is the most appropriate for us to send you information regarding your stay.
- ☆ Free Prenatal classes available. Phone us on 09 425 8201 for further information and bookings
- ☆ Warkworth Birthing Centre cannot accept responsibility for valuables belonging to clients.
- ☆ WiFi available.
- ☆ On the day of discharge please try to leave the Centre before lunchtime.
- ☆ Partners welcome to stay in the Centre if desired. Shower facilities available, partner to provide their own meals
- ☆ Visiting hours for all family and friends 3pm - 6pm.

The privacy act 1993 requires that before we can share your and your baby's Medical Information with Health Professionals involved in your case we need your consent. Signing this form indicates your consent.

Signed: (Mother) _____ Date: _____

Signed: (LMC) _____ Reg No: _____

☐ COMPUTER ☐ RECEIVED EMAIL SENT

OFFICE USE ONLY

Your Postnatal Midwife must have a current Access Agreement.