

MITCHAM
PRIVATE HOSPITAL

27 Doncaster East Road Mitcham Vic 3132
Ph: (03) 9210 3222 Fax: (03) 9210 3223

**MOTHER BABY SUPPORT
UNIT INTAKE FORM**

OFFICE USE ONLY

Unit Record Number:

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Family Name: _____

Given Names: _____

Date of Birth:

--	--	--	--	--	--	--	--	--	--

Age:

--	--	--

Sex:

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Room No.:

--	--	--

OR USE LABEL

MOTHER'S INFORMATION

Full Name: _____ Date of Birth: ____ / ____ / ____

Address: _____ Place of Birth: _____

Suburb: _____ Postcode: _____

Home Phone: _____ Mobile Phone: _____

Where did you hear about the Mother Baby Unit?: _____

Are you interested in: (refer to enclosed pamphlet - please tick) Day Program In Patient Program (4 nights)

MOTHER'S DETAILS

Ages of any other children: _____

Past history of: Depression Anxiety Psychiatric Illness

If yes, when did this illness occur? (list treatment and medication) _____

Existing Problems?: Depression Anxiety Sleep Deprivation Feeding Problems

Have you had a fall in the past 12 months? Yes No

Other?: (please explain) _____

Is there a Paediatrician / Psychiatrist / Psychologist involved in care?: Yes No

Name: _____ Phone: _____ Fax: _____

Name: _____ Phone: _____ Fax: _____

Name of GP: _____ Phone: _____ Fax: _____

Special dietary requirements: _____

Allergies?: (what to and reaction) _____

Medications: (what medication and what for) _____

Present and previous employment: _____

If returning to work, when?: _____

Hobbies / Interests: _____

Please complete questions on reverse

FATHER'S INFORMATION

Full Name: _____
Mobile Number: _____ Work Contact Number: _____
Occupation: _____

CHILD'S INFORMATION

Full Name: _____ Date of Birth: ____ / ____ / ____
Sex: Male Female Hospital where born: _____
Birth Weight: _____ Length: _____ Head Circumference: _____
Any birth complications?: _____
Any previous Mother Baby Support Unit admissions?: _____

Day Program In Patient Program (4 nights)
Where and when?: _____

Existing Problems?: Sleep Feeding Colic Reflux
Other?: (please explain) _____

Special dietary requirements?: (i.e. finger food, puree, allergies) _____
Immunisations: 2 months 4 months 6 months 12 months Next Due: _____
Medications: (what medication and what for) _____

Allergies: (what to and reaction) _____

MATERNAL AND CHILD HEALTH NURSE INFORMATION

Full Name: _____
Address: _____
Contact Number: _____
Last Visit: _____ Next Visit: _____
Do you have a mother's group / play group?: (give details) _____

HEALTH FUND & MEDICARE DETAILS

Medicare Number: _____ Expiry Date: _____
Mothers Number on Card: _____ Baby Number on Card: _____
Name of Health Fund: _____ Family Cover? Yes No
Membership Number: _____ Table: _____
How long have you been with this fund?: _____