

**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:

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Age:

--	--	--

Sex:

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Room No.:

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**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

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?: \_\_\_\_\_