Right from the Start

PRENATAL REGISTRATION

Please save your completed form and email to rfts@viha.ca

We believe that your lived experience matters. This form helps us to learn about you, from you. Following review of this form, a public health nurse may contact you to discuss what public health supports are available to you.
The information you provide on this form becomes part of your confidential health record.
For help filling out this form, or for more information, call your local health unit (http://www.viha.ca/locations/health_units.htm).

PREGNANCY AND YOU		
Today's date (y/m/d):	Care card #:	
Your birth date (y/m/d):	Your age: _____	
Your due date (y/m/d):	How many weeks pregnant are you? _____weeks	
Have you given birth to other children? ☐ yes ☐ no	How many? _____	
YOUR NAME AND CONTACT INFORMATION		
Last name:	First name:	
Street address:	City:	Postal code:
Mailing address *(if different from above)*:	City:	Postal code:
Phone number(s): Home: _____	Work: _____	Cell: _____
Which phone number is best to reach you at? ☐home ☐work ☐cell	Is it ok to leave a message? ☐yes ☐no	
If you do not have a phone, how can we reach you?		
YOUR HEALTH CARE TEAM		
Name of Doctor or Midwife:	City:	Phone#: *(optional)*
Name of hospital where you plan to deliver your baby:		
How many months pregnant were you at your first prenatal doctor or midwife visit? ☐ 1-3 months ☐ 4-6 months ☐ 7-9 months		
Are you interested in learning more about any of the following maternal health promotion topics? (*please select topics of interest*) ☐ Breastfeeding support ☐ Safer infant sleep ☐ Prenatal or labour and birth classes offered in your community		
Are you going to an outreach program for pregnant women in your community? ☐ yes ☐ no	If yes: ☐ At your local First Nations Health Centre ☐ Other (specify):_____	
INFORMATION ABOUT YOU		
How long have you lived in Canada?	☐ Born in Canada ☐ Less than 5 years ☐ 5-10 years ☐ 10 years +	
Do you identify as having Aboriginal heritage?	☐ yes ☐ no	
Did you come to Canada as a refugee?	☐ yes ☐ no	
Do you need an interpreter?	☐ yes ☐ no	
What language do you speak?	☐ English ☐ Indigenous (Aboriginal) ☐ Other:	
What was the highest grade you finished in school?		
Do you talk to someone when you are upset or worried or just need to talk?	☐ yes ☐ no	
Do you have someone that can help you out with transportation, housing, childcare or other needs?	☐ yes ☐ no	
Do you find it very hard to live on the money you make?	☐ yes ☐ no	
During the past month, have you often felt down, depressed or hopeless?	☐ yes ☐ no	
During the past month have you often lost interest in doing things?	☐ yes ☐ no	
Please check ONE of the following boxes about smoking:	☐ I have never smoked cigarettes	☐ I currently smoke cigarettes
	☐ I quit smoking **less** than 1 year ago	☐ I quit smoking **more** than 1 year ago
How often do people smoke around you? ☐ Daily ☐ Weekly ☐ Monthly ☐ Less than monthly ☐ Never		
PUBLIC HEALTH NURSE COMPLETES THIS SECTION		
Name of PHN:_____	Health Unit: _____	NFP: ☐ yes ☐ no
_____ Signature of PHN	_____ Date (ymd)	NOTES:

Thank you for registering with the Island Health's Right from the Start program.