



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? <input type="checkbox"/> yes <input type="checkbox"/> 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? <input type="checkbox"/> home <input type="checkbox"/> work <input type="checkbox"/> cell	Is it ok to leave a message? <input type="checkbox"/> yes <input type="checkbox"/> 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? <input type="checkbox"/> 1-3 months <input type="checkbox"/> 4-6 months <input type="checkbox"/> 7-9 months		
Are you interested in learning more about any of the following maternal health promotion topics? (please select topics of interest)		
<input type="checkbox"/> Breastfeeding support <input type="checkbox"/> Safer infant sleep <input type="checkbox"/> Prenatal or labour and birth classes offered in your community		
Are you going to an outreach program for pregnant women in your community? <input type="checkbox"/> yes <input type="checkbox"/> no	If yes: <input type="checkbox"/> At your local First Nations Health Centre <input type="checkbox"/> Other (specify): _____	
INFORMATION ABOUT YOU		
How long have you lived in Canada?	<input type="checkbox"/> Born in Canada <input type="checkbox"/> Less than 5 years <input type="checkbox"/> 5-10 years <input type="checkbox"/> 10 years +	
Do you identify as having Aboriginal heritage?	<input type="checkbox"/> yes <input type="checkbox"/> no	
Did you come to Canada as a refugee?	<input type="checkbox"/> yes <input type="checkbox"/> no	
Do you need an interpreter?	<input type="checkbox"/> yes <input type="checkbox"/> no	
What language do you speak?	<input type="checkbox"/> English <input type="checkbox"/> Indigenous (Aboriginal) <input type="checkbox"/> 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?	<input type="checkbox"/> yes <input type="checkbox"/> no	
Do you have someone that can help you out with transportation, housing, childcare or other needs?	<input type="checkbox"/> yes <input type="checkbox"/> no	
Do you find it very hard to live on the money you make?	<input type="checkbox"/> yes <input type="checkbox"/> no	
During the past month, have you often felt down, depressed or hopeless?	<input type="checkbox"/> yes <input type="checkbox"/> no	
During the past month have you often lost interest in doing things?	<input type="checkbox"/> yes <input type="checkbox"/> no	
Please check ONE of the following boxes about smoking:	<input type="checkbox"/> I have never smoked cigarettes	<input type="checkbox"/> I currently smoke cigarettes
	<input type="checkbox"/> I quit smoking less than 1 year ago	<input type="checkbox"/> I quit smoking more than 1 year ago
How often do people smoke around you?	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Less than monthly <input type="checkbox"/> Never	
PUBLIC HEALTH NURSE COMPLETES THIS SECTION		
Name of PHN: _____	Health Unit: _____	NFP: <input type="checkbox"/> yes <input type="checkbox"/> no
Signature of PHN _____	Date (ymd) _____	NOTES:

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