fraserhealth

PRENATAL REGISTRATION FORM (Please Print)

Thank you for registering for the Fraser Health – Best Beginnings Program.

A public health nurse will review the information you provide. This information becomes part of your confidential medical record. Some individuals will receive a call from the public health nurse to connect them with helpful resources and supports. All individuals who complete the registration will receive a pregnancy information package.

YOUR NAME AND CONTACT INFORMATION (PLEASE PRINT CLEARLY – THANK YOU)			
Today's Date year/month/day	Personal Health Number (if available)		Sex* ☐ F ☐ M ☐ Intersex/X*
Last Name	First Name		Preferred Name
Street Address	City		Postal Code
Phone Numbers Home:	Cell:	Which phone number is best to reach you at? ☐ Home ☐ Cell	
☐ I consent to receive text messages at the cell phone number I gave above for booked appointments or texts with important health information, or a text to provide feedback on my services. I can reply "STOP" at any time to stop receiving text messages.			
Is it okay to leave a text/voice message on your phone? ☐ Yes ☐ No	If you do not have a phone how can we reach you? _____		
What is the best time to call during the week? ☐ Weekdays ☐ Weekends			
When is the best time to call? ☐ Anytime ☐ Morning before 12pm ☐ Afternoon 12-4pm ☐ Evening 4pm-7pm ☐ Not available during the day			
Your email address: _____	☐ I'd like to receive emails about pregnancy and parenting news		

YOUR HEALTH CARE TEAM			
Name of Doctor, Nurse Practitioner, 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, Nurse Practitioner, or Midwife visit? ☐ 1-3 months	☐ 4-6 months	☐ 7-9 months	
Are you attending, or do you plan to attend prenatal education classes?	☐ Yes	☐ No	
Are you attending any of the pregnancy outreach or support programs listed below? ☐ Yes ☐ No	If yes, please check appropriate box below		
☐ POPS Program	☐ Best For Babies	☐ Kla-how-eya Aboriginal Centre	☐ Maxxine Wright Community Health Centre
☐ Better Beginnings	☐ Healthy Babies	☐ Healthiest Babies Possible	☐ Other (Name or Program)

INFORMATION ABOUT YOU				
Your Birth Date year/month/day	Your Age			
What is your due date? year/month/day	How many weeks pregnant are you today? _____weeks			
With this baby, will you be a first time parent? ☐ Yes	☐ No			
How long have you lived in Canada? ☐ Born in Canada	☐ Less than 5 years	☐ 5-10 years	☐ More than 10 years	
Did you come to Canada as a refugee? ☐ Yes	☐ No			
Would you need an interpreter to speak with the nurse? ☐ Yes	☐ No			
If you need an interpreter, what language do you speak?	☐ Punjabi ☐ Mandarin ☐ Cantonese ☐ Tigrigna ☐ Korean ☐ Ukrainian ☐ French ☐ Vietnamese ☐ Farsi ☐ Other (name of language)			
Do you wish to disclose your Indigenous heritage? ☐ Yes ☐ No	☐ Prefer not to say	If yes, ☐ First Nations ☐ Inuit or ☐ Metis		
First nation status	☐ Status Indian ☐ Non-Status Indian ☐ Prefer not to say			
Do you predominantly live on a reserve? ☐ Yes ☐ No	☐ Prefer not to say	If yes, band name _____		
Do you receive the majority of services on reserve? ☐ Yes ☐ No	If yes, which Indigenous organization _____			
Do you wish to disclose your racial group? (select all that apply) ☐ Yes ☐ No	☐ Prefer not to say	If yes, ☐ Latin American ☐ Middle Eastern ☐ East Asian ☐ Black ☐ South Asian ☐ South East Asian ☐ White ☐ Another Race (specify) _____		
Have you completed high school? ☐ Yes ☐ No				

Do you have someone you can talk to when you are upset or worried or just need to talk?	☐ Yes	☐ No
Do you have someone who can help you out with transportation, housing, childcare or other personal needs?	☐ Yes	☐ No
Are you finding it very difficult to live on your total household income?	☐ Yes	☐ No
Do you receive income assistance (e.g., disability, income assistance, employment insurance)?	☐ Yes	☐ No
During the past month have you often been bothered by feeling down, depressed or hopeless?	☐ Yes	☐ No
During the past month have you often been bothered by little interest or pleasure in doing things?	☐ Yes	☐ No

Please tick **ONE** of the check boxes about tobacco/vape	☐ I have never smoked cigarettes/vape		☐ I currently smoke cigarettes/vape	
	☐ I quit smoking/vaping less than 1 year ago		☐ I quit smoking/vaping more than 1 year ago	
How often do people smoke/vape around you?	☐ Daily	☐ Weekly ☐ Monthly	☐ Less than Monthly	☐ Never
Are you planning to breast/chest feed your baby?	☐ Yes	☐ No ☐ Not decided yet		

How did you hear about the Best Beginnings Program? Select all that apply

☐ Fraser Health's social media channels ☐ Fraser Health's website ☐ Internet Search (e.g. Google) ☐ Poster ☐ Friend/Family Member
☐ Primary Care Provider (e.g. nurse, midwife, doctor) ☐ Other (specify) _____

*** As shown on BC Services card * If Available**