Ramsay Health Care

EARLY PARENTING CENTRE
Pre-Admission Assessment

URN: _____

Surname: _____

Given Name: _____

DOB: _____ Gender: _____

(Affix Patient ID label here)

In order to assess your health needs and facilitate your booking and admission we need some background information. To be returned with Medical Referral & Edinburgh Post Natal Depression Scale

First Name: _____ Surname: _____ Sex: ☐ Male ☐ Female

D.O.B: _____ Current Age: _____ Country of Birth: _____ Aboriginal/Torres Strait: ☐ Yes ☐ No

Address: _____ Suburb: _____ Post code: _____

Health Fund Name: _____ Health fund Number: _____ Religion _____

Medicare Number: _____ Reference Number: _____ Expiry Date _____

Reason for admission to the Parenting Centre:

☐ Sleep & Settling ☐ Breast / feeding ☐ Other: _____

Parent / Carer 1

Title: _____ First Name: _____ Surname: _____

Date of Birth: _____ Country of Birth: _____ Relationship to patient: _____

Phone: _____ Email: _____

Parent / Carer 1

Title: _____ First Name: _____ Surname: _____

Date of Birth: _____ Country of Birth: _____ Relationship to patient: _____

Phone: _____ Email: _____

How did you hear about the Early Parenting Centre?:

Have you and your baby been admitted to another Early Parenting Centre recently? If so please give the name of the hospital or program and date of admission.

Have you been a patient at this Hospital in the past? ☐ Yes ☐ No Details: _____

Obstetric History

In which hospital was your baby born?

How many pregnancies have you had? Number of children?

Have you had any miscarriages?

Please answer this question in regards to your most recent pregnancy and birth

Was this baby's conception – *(Tick one)*
☐ Spontaneous & expected ☐ Spontaneous & unexpected
☐ Assisted by reproductive technology ☐ Adoption ☐ Surrogacy

Were you admitted to hospital and any stage during this pregnancy? If so what was the admission for?

How many weeks gestation were you when you gave birth?

How was your baby born – *(Tick one)*
☐ Spontaneous vaginal birth ☐ Instrumental vaginal birth ☐ Induction
☐ caesarean section without labour ☐ caesarean section with labour.

What was your baby's birth weight?

Were there any complications for you or your baby at the birth? If so describe them?

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Family

Who are your supports in your family?

To what extent are they able to help you?

Dietary Requirements

Do you or your baby require a special diet? Please specify:

Parent: ☐ Gluten free ☐ Soy free ☐ Diary free ☐ Vegan ☐ Vegetarian ☐ Diabetic ☐ Coeliac

Are you on an elimination diet for Breastfeeding? Please specify: _____

Baby: Does your baby eat? ☐ Puree ☐ Mash ☐ Cut up ☐ Toddler meal (family food)

Food Intolerance: Please list food & reaction

Baby: _____

Parent: _____

Please think about your baby's health, behaviour & development and tell us in general terms how these have been in recent times

How many hours does your baby sleep during the day between 7am-7pm?

Approximately how long does your baby sleep for each sleep? _____hrs_____mins

How often does your baby wake overnight between 7pm & 7am? ☐ Once ☐ 2-3 times ☐ More than 3 times

In total how many hours does your baby sleep in 24hours? ☐ 10hrs or less ☐ 11-12 hours ☐ 13 hours or more

In general how long does your baby cry/ fuss for in 24 hours? ☐ Less than 2 hrs ☐ 2-4 hours ☐ more than 4 hours

Please describe your baby's cry: _____

In general how long does your baby cry for? ☐ 10minutes or less ☐ 10-20 minutes ☐ more than 20 minutes

Has your baby been diagnosed with any of the following medical conditions?

☐ Allergies ☐ Reflux ☐ Lactose intolerant ☐ Low weight gain / failure to thrive

☐ other please specify_____

Is your baby currently taking prescribed medications? Please list

Is your baby taking other medications or supplements? Please list

How is your baby currently fed? ☐ Breastfeeding ☐ Expressed breastmilk ☐ formula ☐ Cow's milk ☐ Other

How many feeds does your baby have in 24 hours? ☐ More than 8 feeds ☐ 6-8 feeds ☐ 4-6 feeds ☐ up to 4 feeds

Is your baby immunised? ☐ Yes ☐ No Next immunisation due _____

Please provide copy of immunisation record (Childhealth book or Medicare Immunisation History)

Would you accept a cancelation and come in at short notice? ☐ Yes ☐ No

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Physical needs

Do you have Heart Disease ☐ Yes ☐ No

Diabetes ☐ Yes ☐ No ☐ Type 1 ☐ Type 2 ☐ Gestational

Asthma ☐ Yes ☐ No ☐ Mild ☐ Moderate ☐ Severe

Hepatitis ☐ Yes ☐ No ☐ A ☐ B ☐ C

Allergies ☐ Yes ☐ No

(please list drug & reaction): _____

Food Intolerance ☐ Yes ☐ No

(please list food & reaction): _____

Do you carry an EPIPEN? ☐ Yes ☐ No

Epilepsy ☐ Yes ☐ No

Blood Transfusion ☐ Yes ☐ No Date: _____

Do you smoke ☐ Yes ☐ No # per day: _____

Alcohol Consumption ☐ Yes ☐ No # Glasses per week: _____

Have you experienced with recreational drugs in the past or currently ☐ Yes ☐ No

If yes what did you experiment with? _____

Maternal wellbeing

Have you ever seen a mental health professional prior to having your baby? ☐ Yes ☐ No

If YES please tick ☐ Psychologist ☐ Psychiatrist ☐ Counsellor

Dates: _____ Number of sessions: _____

Are you currently seeing a mental health professional? ☐ Yes ☐ No

Are you able to go to sleep easily when you go to bed? ☐ Yes ☐ No

Are you able to get back to sleep easily after caring for your baby overnight? ☐ Yes ☐ No

Do you ever wake up overnight apart from when your baby needs you? ☐ Yes ☐ No

How much sleep do you get in 24 hours? _____

How would you rate your maternal exhaustion? ☐ High ☐ Moderate ☐ Low

Have you felt panicky, irritable, anxious or irritated? ☐ Yes ☐ No

Have you been prescribed antidepressants? Name & Dose ☐ Yes ☐ No _____

Have you been prescribed drugs for anxiety? Name & Dose ☐ Yes ☐ No _____

Are you on any current medications? Please list type of medication and reason for use:

Reproductive Health History

Are you ever incontinent of urine? ☐ Yes ☐ No

Do you still experience pain from an episiotomy/tear/caesarean wound? ☐ Yes ☐ No

Do you have any unhealed wounds from childbirth? ☐ Yes ☐ No

Have you been able to resume your sexual relationship? ☐ Yes ☐ No

Have you had mastitis? ☐ Yes ☐ No

Do you have nipple pain? ☐ Yes ☐ No

Do you have breast pain? ☐ Yes ☐ No

Do you have blocked ducts? ☐ Yes ☐ No

Are you currently expecting another baby? ☐ Yes ☐ No Due date: _____

In addition to caring for your baby, are there any events in your life that are currently worrying or distressing?

If yes please describe: _____

Opt out of My Health Record: ☐ Yes ☐ No

Print Name: _____ Signature: _____ Date: _____

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FOR OFFICE PURPOSES ONLY – TO BE COMPLETED BY HOSPITAL ADMINISTRATION STAFF

REFFERING DOCTOR NAME: _____ PRACTICE _____ PROVIDER _____

CLINICAL DIAGNOSIS: _____ ADMITTING DR: _____

BOOKING CALL 1: Date: _____ Time _____ Contact made: ☐ Message Left: ☐

BOOKING CALL 2: Date: _____ Time _____ Contact made: ☐ Message Left: ☐

BOOKING CALL 3: Date: _____ Time _____ Contact made: ☐ Message Left: ☐

Health Fund checked online: ☐ YES

HF needs following up: ☐ YES ☐ NO

Recheck Health Fund closer to admission date: ☐ YES ☐ NO

Health fund approved: ☐ YES ☐ NO

Any out of pocket cost: ☐ YES ☐ NO

Parent informed of out of pocket cost: ☐ YES ☐ NO

Diet/Allergy: _____

Given booking date: ☐ YES ☐ NO

Date & Room: _____

Paperwork done: ☐ YES ☐ NO

Confirmed: ☐ YES ☐ NO Time: _____

NOTES:

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