



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 – Spontaneous & expected Spontaneous & unexpected
(Tick one) 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 – Spontaneous vaginal birth Instrumental vaginal birth Induction
(Tick one) 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 Dairy 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

REFERRING 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:

Large empty area for notes.



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