Seabird Island Health and Stó:lō Service Agency

Temelíle Midwifery Intake Form

Please email completed form to midwives@seabirdisland.ca

Date of Intake request: dd/mm/yy

First Name: Middle Name: Last Name:

Date of Birth: dd/mm/yy Given / Maiden name on your birth certificate: ☐ Same as above

Care Card # Your Height: Current Weight:

Do you identify as Indigenous? If yes, what community are you registered to?

Client status number (if applicable):

Partner's Name:

Does your partner identify as Indigenous? If yes, what community are they registered to?

Partner status number (if applicable):

Do you live on or off reserve (if applicable)? ☐ On Reserve ☐ Off Reserve

If you live on reserve, what community do you live in?

Phone Numbers

Cell:

Home:

Work:

How many times have you been pregnant, including this pregnancy?

Have you had any miscarriages or pregnancy losses?

Email Address:

What is the best way to reach you?

☐ Text
☐ Phone
☐ Email
☐ Family:

Have you ever had a caesarean section (c-section)? If so, Please give details such as date, any complications, number of caesarean sections etc:

What was the first day of your last menstrual period?

dd/mm/yy ☐ Unknown

How often do you have a period? (typical is every 28 days)

Are your periods regular? ☐ Yes ☐ No

Have you had an ultrasound in this pregnancy?

If yes, date: dd/mm/yy Midwife / Family Doctor's name:

Have you been seen by a physician or midwife in this pregnancy? ☐ Yes ☐ No

If yes, Midwife or Physician's name:

When is your baby due?

dd/mm/yy ☐ Unsure of expected due date

Do you have any health issues? ☐ Yes ☐ No

If yes, please give detail(s):

How did you hear about our team?

Submit