For more information:

Register early ~ it's easy!

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Healthy Start - Prenatal Registration Questionnaire
Support during and after your pregnancy

The Healthy Start program offered by Northern Health provides prenatal, postpartum, early childhood, and family services for women, babies, children, and families. These services are provided by interprofessional teams across northern BC.

Primary care nurses (PCNs) work closely with family doctors, nurse practitioners, and midwives during the prenatal period to support you to have the healthiest pregnancy and baby possible. PCNs also offer health promotion information, assessment, support, and referrals to a wide range of community resources.

Register early ~ it's easy!

Printed: Fill out the form inside of this brochure

You can submit your registration two ways:

- In-person: Leave completed form with your doctor at your prenatal appointment or drop it off at any health unit
- Mail: To health unit address on the back of this brochure

Your questionnaire will be reviewed by a primary care nurse who will contact you to discuss what supports and resources you may need.

All women who register will receive a healthy start package that includes a Pregnancy Passport and other helpful resources.

Register early in your pregnancy for Northern Health's ***Healthy Start*** program

Primary care nurses will help you:

- Receive prenatal health information and resources
- Make healthy, informed choices in pregnancy
- Learn about breastfeeding and caring for a new baby
- Get the physical and emotional support you need
- Find community resources that are right for you

Registration is easy:

- Complete the form on the inside of this brochure and return it to your care provider or health unit
- Your registration will be reviewed by a primary care nurse who may contact you to discuss which supports and resources you are interested in
- Your information is CONFIDENTIAL and will become part of your medical record

All women who register will receive an information package that includes Pregnancy Passport and other helpful resources.

Healthy Start Program offers prenatal, postpartum, early childhood, and family services for women, babies, children, and families. These services are provided by interprofessional teams across northern BC. Primary care nurses (PCNs) work with family doctors, nurse practitioners, and midwives to deliver these services. We offer assessment, support, health promotion information, and referral to a wide range of community resources.

Integrated Prenatal Services: offer assessment and are available to support pregnant women and their families to make informed, healthy choices during pregnancy.

Integrated Postpartum Services: are available to support the physical and emotional health of new mothers, their babies, and their families.

Breastfeeding Support: available for telephone and in-person visits to help families breastfeed their babies.

Family Health Services: available to offer information about family planning, parenting support, and referrals for children and families who are in need.

Immunizations and Child Health Clinics: available to offer information and immunizations to prevent communicable diseases; to assess child health, growth and development; and to provide dental, hearing, and vision services.

Find more information online at:
northernhealth.ca

Healthy Start Prenatal Registration Questionnaire (support during and after your pregnancy)

Thank you for registering with the Northern Health's *Healthy Start* program. The information you provide on this form becomes part of your confidential health record. ***Please print***. Need help with the form? Call us. Our number is on the back.

PREGNANCY AND YOU

Today's date: (y/m/d):	Care card #:
Your birth date (y/m/d):	Your age: ______________________
Do you have any medical concerns or questions about your pregnancy?	☐ yes ☐ no
Was this pregnancy planned?	☐ yes ☐ no
Your due date (y/m/d)	How many weeks pregnant are you? ______________________
How many times have you been pregnant? ___________________	
Have you given birth to other children? ☐ yes ☐no How many? ______________________	

YOUR NAME AND CONTACT INFORMATION

Last name:	First name:	
Street address:	City:	Postal Code:
Mailing address:		
Phone number(s): Home: ______________________	Work: ______________________	Cell: ______________________
Email address:		
Which phone number is best to reach you during the daytime hours? ☐ home ☐ work ☐ cell		Is it ok to leave a message/text message? ☐ yes ☐ no
If you do not have a phone, how can we reach you?		

YOUR HEALTH CARE TEAM

Name of doctor, midwife or nurse practitioner:	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?	☐ 1-3 months	☐ 4-6 months	☐ 7-9 months
Are you currently attending, or planning to take prenatal education?	☐ yes	☐ no	
Are you going to a pregnancy support program in your community?	☐ yes	☐ no	

INFORMATION ABOUT YOU

What is your ethnic background?			
Do you have enough of the kinds of foods you want to support your pregnancy? ☐ Always ☐ Sometimes ☐ Never	Are you planning to breastfeed?	☐ yes	☐ no
Have you or any of your children had cavities within the past year or need any teeth repaired?		☐ yes	☐ no
Do you have someone to talk to when you have worries?		☐ yes	☐ no
How satisfied are you with the support you receive from your partner, family and friends in your pregnancy? ☐ Satisfied		☐ A little satisfied	☐ Not satisfied
Do you have someone to help you with (check all that apply): ☐ labour support ☐ childcare ☐ transportation ☐ other ___________			
Did you finish high school? ☐ yes ☐ no	Do you have a safe place to live?	☐ yes	☐ no
How many different places have you lived in the last 2 years?	☐ 1 ☐ 2-3	☐ >3	
Do you find it hard to live on the money you make?		☐ yes	☐ no
Do you have a history of depression or other mental health concerns?		☐ yes	☐ no
During the past month, have you often felt down, depressed or hopeless?		☐ yes	☐ no
During the past month, have you often lost interest in doing things?		☐ yes	☐ no
Have you used any of the following in pregnancy? ☐ Alcohol ☐ Street drugs ☐ Prescriptions/over the counter medications Comments:			

Please check all boxes that apply to your tobacco use:	Have you used any tobacco products in the last 6 months? ☐ yes ☐ no	Have you used any tobacco products in the last 7 days? ☐ yes ☐ no
	If you answered yes to above questions: Have you quit since finding out you were preg-nant? ☐ yes ☐ no	Have you cut down since finding out you were pregnant? ☐ yes ☐ no

How often do people use tobacco around you? ☐ Daily ☐ Weekly ☐ Monthly ☐ Less than monthly ☐ Never
Comments:

PRIMARY CARE NURSE COMPLETES THIS SECTION

Name of nurse:	Health unit/Doctor's office:	Need for enhanced family services ☐ yes ☐ no
______________________ Signature of nurse	______________________ Date signed (y/m/d)	NOTES: