



303-2083 ALMA ST.
VANCOUVER BC V6R 4N6
TEL: 604-224-0686
FAX: 604-221-0574

INTAKE FORM

please enter your name as it appears on your care card

LAST NAME: FIRST NAME: MIDDLE INITIAL:

ADDRESS: CITY: POSTAL CODE:

EMAIL ADDRESS:

TEL: CELL:

DATE OF BIRTH (D/M/Y): CARE CARD #:

FIRST DAY OF YOUR LAST MENSTRUATION: EXPECTED DUE DATE:

PARTNER'S NAME: PARTNER'S PHONE:

ANY RISK FACTORS IN YOUR CURRENT PREGNANCY:

IF YOU HAVE HAD ANY PREVIOUS DELIVERIES, PLEASE BRIEFLY DESCRIBE YOUR EXPERIENCE:

WHAT ARE YOUR PRIMARY REASONS FOR CHOOSING MIDWIFERY CARE FOR THIS PREGNANCY?

WHERE ARE YOU HOPING TO GIVE BIRTH:

BC WOMEN'S HOSPITAL

ST. PAUL'S HOSPITAL

HOME

YOUR FAMILY DOCTOR: DOCTOR'S PHONE:

HOW DID YOU HEAR ABOUT WESTSIDE MIDWIVES:

IF THERE IS ANYTHING ELSE THAT YOU WOULD LIKE TO SHARE WITH US, PLEASE FEEL FREE:

YOUR APPOINTMENT DATE AND TIME: