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Birthing Prep Program Handouts

These forms are to be given to your patients at 30 weeks gestation. Please have your patients fill in the forms and bring them to the Birthing Unit by 34 weeks gestation. They can be dropped off or brought with the patient during their tour, if attending, OR faxed to the unit at (705) 529 1035.

If any questions please call the Birthing Unit at 705-526-1300 extension 5230.

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Welcome to Georgian Bay General Hospital Birthing Unit!

We thank you for choosing GBGH to support and care for you and your family throughout your birthing experience! We strive to provide the best care possible while maintaining patient safety and ensuring your satisfaction with our services!

The following pages contain important information for you and your family as well as pertinent nursing information that we require you to fill out. Once all forms completed please:

- Drop them off in person to the GBGH Birthing Unit
- Bring them with you to your Prenatal Tour (if applicable)
- Fax them to (705) 529 1035

Instructions for Birthing Prep Papers

- The pre-anesthetic questionnaire needs to be signed and dated. Please circle **YES** or **NO** to all questions within the form. This is filled out in advance should you need to have a Caesarean Section during your labour.
- The Nursing Admission Information- please fill out all pages to help nursing get to know you and your family better.
- Labour and Delivery Pre-registration form. Please fill out this form to help expedite your admission when you are in labour.

General Visiting Guidelines:

- Family presence is welcomed 24 hours a day, seven days a week however between the hours of 10:00 pm and 6:00 am are designated quiet times to promote a restful, healing environment for our patients. Family are required to call the nursing station in advance during these times to confirm that the patients is available 705-526-1300 x 5230.
- The number of people welcomed at the bedside at any one time will be determined between the patient and the care team.
- Children under 14 must be under direct supervision (from someone other than the patient) at all times

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General Visiting Guidelines continued:

- **We ask that you respect the privacy of all patients, at all times, when in the hospital**
  - Family presence may be restricted to protect the privacy and rights of patients
  - We may interrupt family presence to provide patient care
  - If asked to leave the room, please comply
- If visitors feel unwell, have an infection or flu-like symptoms, please ask them not visit the hospital.
- After the delivery of your baby **ONE** support person may stay with you overnight. Supports are required to please bring in your own blanket and pillow.

A few things you will need to know about the hospital for your stay:

Cafeteria hours:

Monday to Friday 0930-1030 and 1130-1330

Weekends and holidays closed

Coffee Bar (located in the front lobby) hours:

Monday to Friday 0800-1600

Weekends 1230-1600

Holidays Closed

Gift shop hours:

Monday to Friday 0900-1600 and 1730-1930

Weekends 1200-1600

Holidays closed

Phone/TV/Wireless internet is available for purchase once you are admitted to Obstetrics. Please ask your nurse about the services. Long Distance Phone calls can only be made during switchboard hours, so it is best to bring a calling card if you do not have your own phone.

Parking Passes available for purchase:

- With in and out privileges at the rate of $7 per 24 hours.
- weekly pass: $25
- 15 day pass: $42

You may purchase your parking pass at the parking Kiosk located in the hospital's Main Entrance.

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NURSING ADMISSION INFORMATION

Please tell us about yourself and your pregnancy. This information will help us care for and your baby during this special time. This information is confidential and we ask that you please complete and return to the staff on the birthing unit on 2North.

DEMOGRAPHIC INFORMATION

Patient's Family Name: _____ given

Names(s):_____

Date of Birth: _____

Address: _____ Home Phone: _____

_____ Cell phone: _____

Name of Partner: _____

Contact information (if different from patient):_____

Name of support person(s) who may be present at delivery:

_____

Language spoken at home: English____French_____

Other: _____ ;Interpreter required at hospital: Yes_____No_____

Please let us know if there are any cultural or religious practices that are important for you or your family while in hospital _____

_____

PREGNANCY INFORMATION

How many times have you been pregnant? _____
How many living children do you have? _____
How many miscarriages? _____ How many abortions _____
Type of conception: Spontaneous_____ Assisted Reproduction_____
Type _____
What is your due date? _____
Determined by Ultrasound? _____ OR Menstrual Date? _____
How many ultrasounds have you had? _____
Reasons for ultrasounds?

_____

_____

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Name of Family Doctor/Midwife/NP_____
Phone Number_____
Have you seen a specialist during this pregnancy? Yes_____ No_____
If yes, who: _____
Why:_____
Who will delivery your baby? _____
Health conditions or complications during this pregnancy?_____
_____
Have you required hospitalization during this pregnancy? Yes____No____
Why? _____
_____
Infection and pregnancy:
None_____ Hepatitis A_____ Hepatitis B_____ Hepatitis C_____
HIV_____
Herpes Simplex Virus_____ HPV_____ Seasonal influenza_____
Other_____Unknown_____

Folic Acid/Vitamin use: Before pregnancy_____ during pregnancy_____
Both_____

Medication exposure in pregnancy:
None____Amphetamines (e.g. speed, uppers) ____Anti-emetics (e.g. gravol, diclectin)_____
Herbal or Homeopathic remedies _____ Narcotics (e.g. Methadone, oxys, codeine)_____
Other over the counter medications (e.g. tums)_____ Prescription_____
Thyroid medication_____
Selective serotonin reuptake inhibitors (anti-depressants) _____
Current medications: _____

PREVIOUS DELIVERIES:

Year	**Hospital**	**Gender**	**Weight**	**Length of labour**	**Type of delivery (Vaginal? Caesarean section? Forceps? Vacuums?**

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HEALTH/MENTAL HEALTH

Allergies: Food_____ Drugs_____ Environmental_____ Latex_____

Pre-pregnancy weight: _____

Pre-existing health conditions:
Chronic hypertension(high blood pressure) _____ Diabetes_____
Heart disease_____Thyroid disease_____
Lupus_____ Asthma_____Other_____
Blood type (if known) _____
Blood transfusions_____

Difficulty with bowels: Yes_____ No_____
If yes what aids do you use? _____
Do you have any urinary problems? Yes_____No_____
If yes what happens? _____
Diet: Regular____ Vegetarian (type) _____Diabetic and if so what calories per day_____
Other_____
Vision: Good_____ Wear glasses_____ Wear contact lenses_____
Hearing: Good_____ Wearing hearing aid(s) _____
Dental: Dentures_____ Partial plate_____ Capped teeth_____
Any physical limitations-describe? _____
_____

Mental Health Concerns:

None_____ Anxiety_____ Depression_____ History of postpartum depression_____ Addiction_____ Bipolar_____ Schizophrenia_____
Post-traumatic stress disorder _____ Borderline personality disorder_____
Eating disorder_____ Other_____ Unknown_____
Do you feel safe at home: Yes____No____?
Do you feel safe taking baby home: Yes_____ No_____?

Smoking:

None_____ <10 per day _____ 10-20 per day_____ >20 per day_____
Amount unknown_____ >100 in lifetime (even if no longer smokes) _____
Lives with someone that smokes_____

Alcohol Exposure in pregnancy:

None_____ <1 drink per month_____ 1 drink per month_____
2-3 drinks per month_____ 1 drink per week_____ More than 1 drink per week_____Daily_____ Unknown_____

Drug and substance exposure in pregnancy:

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None_____ Cocaine_____ Gas/glue_____ Hallucinogens_____
Marijuana_____ Methadone_____ Narcotics_____
Opioids_____
Other_____ Unknown_____
Previous history of substance use: Yes_____ No_____
List substances
(s):_____

SOCIAL/CULTURAL
Do you have adequate support at home? Yes_____ No_____
MY support person(s): father of the baby/partner_____ Family_____
Friends_____If no how can we help? _____
Community resources: Public Health_____ CAS_____
Other_____
Are you a single parent: Yes_____ No_____?
If yes, will the father of the baby be involved? Yes_____ No_____
Do you have appropriate housing: Yes_____ No_____?
If no, concerns _____
Newcomer Support (check yes if you are new to Canada): Yes_____ No_____
Please check your highest level of education completed: Grade_____College_____
University_____ Other_____
Have you experienced any recent stress (as)? Describe: _____
_____
Have you experienced any major life events in the past year? _____
_____

BIRTH PLAN: (PLEASE FEEL FREE TO ATTACH A SEPARATE SHEET OF PAPER IN NEEDED).
Before birth_____
_____
During birth _____
_____
After birth _____
_____

PREPAREDNESS FOR BABY
Have you attended prenatal classes: Yes_____No_____For a previous pregnancy_____?
Do you intend to breast feed: Yes_____No_____Unsure_____Both_____
Do you feel prepared for your child(s) birth? Yes_____ No _____
If NO what are your main concerns:_____
_____
_____

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Please complete this form and bring it

PRE-OPERATIVE QUESTIONNAIRE

Name:	*Patient ID Sticker*
Phone Number:	
Contact Person:	

Please list any MEDICATIONS or FOOD ALLERGIES that you have	
ALLERGY	**REACTION**

CURRENT MEDICATIONS TAKEN: Regular and as needed. Include ALL medications including over the counter medications, inhalers, topical, eye drops, pain killers, herbal remedies and vitamins.

Information Source: ❑ Patient ❑ Pharmacy ❑ Medication in possession

❑ See attached list

	MEDICATION/DOSE/NUMBER OF TIMES A DAY TAKEN? (including Aspirin, birth control, vitamins and herbals)
1	
2	
3	
4	
5	

PAST SURGICAL HISTORY please list any operations you have had in the past.

	SURGERY	**LOCATION**	**DATE**
1			
2			
3			
4			
5			
6			

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Circle "YES" or "NO" to the following questions and add comments as required.	YES	NO	COMMENTS
Have you ever had a problem with local or general anaesethetic?	YES	NO	
Has anyone related to you ever had a problem with an anaesthetic?	YES	NO	
Do you or anyone in your family have a history of malignant hyperthermia OR pseudo cholinesterase deficiency?	YES	NO	
Do you have any history of latex allergy?	YES	NO	
Can you open your mouth fully?	YES	NO	
Do you have pain or difficulty when you move your neck?	YES	NO	
Do you have capped or loose teeth? Dentures?	YES	NO	
Have you been told that it is difficult to put a breathing tube into your wind pipe by a doctor?	YES	NO	
Have you had an injury or surgery to back/neck/jaw?	YES	NO	
Have you had a recent fall?	YES	NO	
Do you use a cane, walker or other mobility device?	YES	NO	
Do you have any prostheses- knee or hip replacement/or other?	YES	NO	
Do you have shortness of breath with exertion or normal activity?	YES	NO	
Do you have a productive cough?	YES	NO	
Do you have asthma?	YES	NO	
Do you have chronic bronchitis/emphysema/recurrent pneumonia?	YES	NO	
Do you use oxygen at home?	YES	NO	
Have you had tuberculosis or been exposed?	YES	NO	
Do you smoke? How many cigarettes per day?	YES	NO	
Do you snore loudly enough to be heard from another room with the door closed?	YES	NO	
Have you been told that you stop breathing when you are asleep?	YES	NO	
Do you often feel tired, fatigued or sleepy during daytime?	YES	NO	
Have you been diagnosed with obstructive sleep apnea? Do you require CPAP?	YES	NO	
Do you get chest pain or angina? How often?	YES	NO	
Have you had a heart attack? Any other heart problems?	YES	NO	
Have you had heart surgery? Do you have an artificial heart valve/stents?	YES	NO	

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Circle "YES" or "NO" to the following questions and add comments as required.	YES	NO	COMMENTS
Do you have congestive heart failure?	YES	NO	
Do you have high blood pressure? Do you take medication for this?	YES	NO	
Have you had rheumatic fever / a heart murmur? (i.e. mitral valve prolapse).	YES	NO	
Do you require antibiotics prior to dental cleaning / dental work?	YES	NO	
Do you have a pacemaker / implantable cardio defibrillator (ICD)? Date of last pacemaker/ICD check: _____	YES	NO	
Have you had a stroke / TIA (mini stroke)?	YES	NO	
Have you had a DVT or blood clots or phlebitis (e.g. in your legs or lungs)?	YES	NO	
Do you have, or have you had hepatitis/jaundice/liver disease?	YES	NO	
Do you have bowel disease?	YES	NO	
Do you have kidney problems?	YES	NO	
Do you have hiatus hernia / heartburn (acid reflux)?	YES	NO	
Do you have disease of nerves and muscles?	YES	NO	
Do you have seizures / epilepsy / black outs?	YES	NO	
Do you have mental health problems? Depression? Anxiety?	YES	NO	
Do you have memory problems (for example Alzheimer's)?	YES	NO	
Do you have anemia?	YES	NO	
Do you have bleeding disorders?	YES	NO	
Are you at risk for sickle-cell disease? (e.g. African or Caribbean descent)	YES	NO	
Have you had previous blood transfusion? When/Where?	YES	NO	
Have you had an organ or bone marrow transplant?	YES	NO	
Do you have or have you had cancer?	YES	NO	
Did you receive chemotherapy/radiation?	YES	NO	
Have you been on Prednisone or other steroids?	YES	NO	
Do you have diabetes? Circle: Insulin Pills Diet	YES	NO	
Do you take thyroid pills? Circle: Hypothyroid Hyperthyroid	YES	NO	
Do you have pituitary or adrenal disease?	YES	NO	
Do you have arthritis?	YES	NO	
When was your last menstrual period? Date: (yyyy/mm/dd)	YES	NO	

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Circle "YES" or "NO" to the following questions and add comments as required.	YES	NO	COMMENTS
Could you be pregnant at this time?			
Do you use recreational drugs?	YES	NO	
Do you drink caffeinated beverages (coffee, tea, and cola)?	YES	NO	
Do you drink alcohol? If yes, drinks per week?	YES	NO	
Are you taking prescription medication for chronic pain?	YES	NO	
Do you have glaucoma/eye problems? History of cataract surgery?	YES	NO	
Do you have body piercings? Where are they?	YES	NO	
Any other health concerns you should tell us about?	YES	NO	
Do you have any or have you had exposure to HIV, Hepatitis?	YES	NO	
Do you have or have you been exposed or tested for VRE, MRSA, ESBL or any communicable disease?	YES	NO	
Have you been admitted to hospital in the last 12 months?	YES	NO	

Patient/Guarantor/Power of Attorney:	Date:
Reviewing Nurse's Signature:	Date:

Nursing Notes:					
HT: cm	WT: kg Pre Preg wt kg	BMI	BP	P	O2Sat
Inspirometer given: YES NO		Reviewed Pre- and Post-Op Instructions: YES NO			
Patient understands proposed procedure?					
Signature:					

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COMMENTS

September 2015

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LABOUR AND DELIVERY PRE-REGISTRATION

Date:	
Name:	
Street Address:	
Mailing Address:	
City:	Postal Code:
Telephone:	Birth Date:
Health Card Number & Version Code:	
Name of Insurance:	
Employer of Insurance Holder:	
Name of Insurance Holder:	
Relationship to Patient:	
Identification #/Certificate #:	
Group/Plan #:	
Family Physician:	
Delivering Physician:	
Spouse Name or Next of Kin:	
Relationship:	
Addresses and Telephone same as Patient: Yes No	
Note if different address:	
Expected Date of Delivery:	

(01/10)

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What you will need during your stay with us:

Labour and Delivery:

Watch (optional: there's an app for that)

Lip Protection (prevent dry lips)

Lotion (unscented)

2 pairs of socks

Housecoat

Underwear

Hair brush, straightener, blow dryer, and accessories

Kleenex

Music or heat pack for labour support

Baby Care Items

Diapers (newborn size)

Baby blanket

Baby wipes/wash cloths

Diaper oil (coconut oil, Vaseline)

Comb

Sleepers, Hats, outfits

Car Seat*

*Bring closer to discharge time

After Delivery

Toiletries (toothbrush, toothpaste, soap, shampoo)

Water bottle

Underwear

Pen to fill out government documents

Housecoat

Slippers/sandals

Bra (one cup larger than pre delivery)

Night gowns

Sanitary Napkins (maxi pads- NO tampons)

Change of comfortable clothes

Comfortable pillow

Clothes, pillow, blanket, snacks, meals for supports*.

* HOSPITAL WILL NOT PROVIDE MEALS FOR SUPPORTS

**Please remember we are a scent FREE facility. Please remember to refrain from wearing colognes/perfumes when coming to the hospital. Do not bring in other scented products or flowers. We are also a latex free environment.