gateway health

Client Information	
Family Name	
Given Name	
Date of Birth	
URN	

HEALTHY MOTHERS, HEALTHY BABIES CLIENT INTAKE

Client Information

Date of Referral		**Is the potential client aware of this referral?**	☐ **Yes**	☐ **No**	
First Name		**Date of Birth**			
Last Name					
Address					
Home No.		**Mobile No.**			
Email Address					

Country of Birth		**Language Spoken**	
VISA			
Indigenous Status	☐ **Aboriginal**	**Mob**	
	☐ **Torres Strait Islander**		
	☐ **Both**		
Concession Card No.		**Concession Type**	
Medicare No.			

Emergency Contact

Full Name		**Contact No.**	
Relationship to Client			

Child/Children

First Name		**Last Name**	
Date of Birth		**Gender**	
First Name		**Last Name**	
Date of Birth		**Gender**	
First Name		**Last Name**	
Date of Birth		**Gender**	

Est. Due Date for Birth?	
Who else lives with you?	

gateway health

Client Information	
Family Name	
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HEALTHY MOTHERS, HEALTHY BABIES CLIENT INTAKE

What Other Services/People are Supporting you?	
☐ GP Only	
☐ Midwife	
☐ Midwife/GP Shared	
☐ Obstetric	
☐ Emergency Relief (Food)	
☐ Transport	
☐ Other Services/Support	

☐ Have you booked into Hospital?	
☐ Have you booked any Scans?	
☐ Have you booked in Immunisations?	

DHHS: Previous or Current	
Family Violence	
Court Orders	
Mental Health	
Problematic Substance Use	