Community Midwifery Program
APPLICATION FORM

Government of Western Australia
Department of Health

TOPAS		MBL		Email	
STORK		ABM		Parity	
EDB					

Received	Entered	Previous CMP	Allocated /Declined	Manager initials	Midwife	Midwife informed	UMRN	Client email

All information, including the **PATIENT REGISTRATION FORM** **must** be completed for your application to be assessed

CLIENT DETAILS

Given name/Surname					Maiden Name		
Father/partner's name							
Residential address							
Suburb				Postcode			
Phone	Mobile		Home		Work		
Email							
Applicant's date of birth		Age		Medicare number			
Pre-pregnancy weight		Height		BMI **(office use only)**			
Do you require an interpreter?		If so, please give details (i.e. limited mobility, hearing deficit)					
Do you have special needs?							
Do you have a carer?		Name of carer					

YOUR DOCTOR (Please give FULL name and address)

Name			
Address			
Postcode		Phone	

THIS PREGNANCY

Preferred place of birth (please select ONE option only

☐**Home** ☐**Kalamunda** ☐**Family Birth Centre** ☐**KEMH** ☐**Armadale** ☐**Fiona Stanley** ☐**Rockingham**

Expected date of birth		How many babies have you birthed?		Previous CMP Client?	**Yes** ☐ **No** ☐
Do you have any current illnesses or medical problems OR have you had any problems with previous pregnancies or births? ***i.e. heavy bleeding, caesarean, high blood pressure, diabetes***					
If yes, please give details or contact the Midwifery Manager at cmp.wchs@health.wa.gov.au					

"I confirm that I will comply with the CMP minimum standards of screening tests in pregnancy to include an ultrasound scan and a blood test to check my iron levels and blood group" **Yes** ☐ **No** ☐
In an emergency, would you accept a blood transfusion? **"** **Yes** ☐ **No** ☐
Are you currently taking any medication? **Yes** ☐ **No** ☐If yes, give details:

Please fax, email or post your completed application form to CMP Administration:
Mail: Internal Box 86, Lakeside Shopping Centre, 420 Joondalup Drive, Joondalup WA 6027
Email: cmp.wchs@health.wa.gov.au
Fax: 9301 9218

Community Midwifery Program

By submitting this application you give your consent to the Community Midwifery Program sharing your medical records with other Health Professionals involved in your care and in case of emergency, you authorise any member of the CMP to take all appropriate measures to support your antenatal, birth and postnatal care. All information will be treated as strictly confidential.

Version 18 – 11.4.17