



Community Midwifery Program APPLICATION FORM

EDB:	
Parity:	
Res Ltr:	

OFFICE USE ONLY

Client ID	Date received	Date entered	Allocated/ Declined	Midwife	Backup	Midwife informed	Client Ltr sent

CLIENT DETAILS

Mother's full given name: _____

Father/partner's name: _____

Mother's maiden name: _____

Residential address: _____

Suburb: _____ Postcode: _____

Postal address: _____ Postcode: _____
(if different from above)

Telephone numbers:
Home: _____ Work: _____ Mobile: _____

Email address: _____

Mother's date of birth: _____

Country of origin/ethnicity: Caucasian Aboriginal/Torres Strait Islander Asian
 Afro Caribbean Polynesian Maori Other

Do you require the services of an interpreter? Yes No

YOUR DOCTOR (Please give full details)

(Either your specialist doctor or your family GP)

Name: _____ Phone: _____

Address: _____
Postcode: _____

Do you have a current Medicare card? Medicare No.: _____

Do you have a current Health Care Card?

Do you have any special needs? Yes No *(i.e. limited mobility, hearing deficit)*

Do you suffer from any serious illnesses or medical conditions? Yes No

If yes, please indicate nature of illness/condition

THIS PREGNANCY

Expected date of birth: _____

How many babies have you birthed?

(e.g. 1, 2, 5,...) _____

Preferred place of birth: Home Hospital

Please note that CMWA is currently not allocating places on the CMP to VBAC women. We do however encourage women wishing for a VBAC to submit an application so that CMWA can evidence demand for this service in the future.

Did you have any problems with previous pregnancies or births?

Yes No

If yes, please give details or contact the Midwifery Manager at cmp@cmwa.net.au

Do you have a preference for a particular midwife, if she is available?

Yes No

Which midwife? _____

Have you used the Community Midwifery Program for previous pregnancies?

Yes No

Additional comments

(Please feel free to tell us anything you think is relevant to your application)

How did you find out about our Community Midwifery Program?

- Friends & Family Birthing Centre / KEMH Phone Book Internet Newspaper Article Newspaper Advert
 GP / OBS Pamphlet / Card Expo / Community Event Other - *(please specify)*

Signed: _____

Date: _____

Thank-you for your application for a place on CMWA's Community Midwifery Program.

Please note that applications are assessed on a first-in-first served basis.

All information will be treated as strictly confidential.

Please fax, email or post your completed Application Form to CMWA:

Mail : PO Box 1336, Fremantle, WA 6959. **Tel :** 9430 6882 (inquiries) **Fax :** 9430 6068

Email : cmp@cmwa.net.au