For more information:

HealthyStart@northernhealth.ca

Pregnancy Support Questionnaire

Northern Health offers prenatal, postpartum, early childhood, and family services for parents, infants, young children, and their families. These services are provided by Primary and Community Care interprofessional teams across northern BC.

Primary care nurses (PCNs) work with doctors, nurse practitioners, midwives and others health professionals to deliver these services. We offer assessment, screening, support, health promotion and education, and referral to community resources.

Printed: Fill out the form inside of this brochure

You can submit your questionnaire two ways:

- In-person: Leave completed questionnaire with your primary care provider (e.g., family doctor, midwife, nurse practitioner) at your prenatal appointment or drop it off at any health unit
- Mail: To health unit address on the back of this brochure

Your questionnaire will be reviewed by a PCN who will contact you to discuss what supports and resources you are interested in.

All pregnant parents who complete this questionnaire will be offered a list of pregnancy resources.

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10-420-6117 (FF06345–IND–Rev.–05/23)

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Prenatal, Postpartum, Early Childhood, and Family Services

Primary care nurses (PCN) will help you:

- Receive pregnancy information and resources
- Make healthy choices in your pregnancy
- Learn about breastfeeding and caring for a new baby
- Get the physical and emotional support you need
- Find community resources that are right for you

Pregnancy Support Questionnaire:

- Complete the questionnaire on the inside of this brochure and return it to your care provider or health unit
- Your questionnaire will be reviewed by a PCN who will contact you to discuss which supports and resources you are interested in
- Your information is **confidential** and will become part of your medical record

All pregnant parents who complete this questionnaire will be offered a list of pregnancy resources.

Northern Health offers prenatal, postpartum, early childhood, and family services for parents, infants, young children, and their families. These services are provided by Primary and Community Care Interprofessional teams across northern BC. Primary care nurses (PCNs) work with doctors, nurse practitioners, and midwives to deliver these services. We offer assessment, screening, support, health promotion and education, and referral to community resources.

Prenatal Services: to offer support and information for pregnant parents; to answer questions, address concerns, and make referrals as needed.

Postpartum Services: to support the physical and emotional health of new parents, newborns, and their families; to answer questions, address concerns, provide resources, and make referrals as needed.

Breastfeeding Support: to help families breastfeed their babies (available for telephone and in-person visits).

Early Childhood and Family Services: to assess the health of children, parents, and family; to monitor growth and development; to provide dental, hearing, and vision services; and to offer information about family, parenting support, and referrals for children and families who need extra support.

Immunization Services: to offer information and routine immunizations to prevent communicable diseases.

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Pregnancy Support Questionnaire

The information you provide on this questionnaire becomes part of your confidential health record.

Please print. Need help with the form? Call us. Our number is on the back.

PREGNANCY AND YOU			
Today's date (y/m/d):	Last name:	First name:	
Care card #:	Your birth date (y/m/d):	Your age:	
What is your due date (y/m/d)?	How many weeks pregnant are you?		
With this baby, will you be a first time parent? ☐ yes ☐ no	Was this pregnancy planned? ☐ yes ☐ no		
If you answered no to the above question; Have you given birth to other children? ☐ yes ☐ no How many:			
How many times have you been pregnant?			
Street address:	City:	Postal code:	
Mailing address:	Email address:		
Phone number(s): Home:	Cell:		
Which phone number is best to reach you at? ☐ home ☐ cell	Is it ok to leave a voicemail/text message? ☐ yes ☐ no		
If you do not have a phone: How can we reach you?			
YOUR HEALTH CARE TEAM			
Name of your family doctor, midwife, or nurse practitioner:	City:	Phone #: *(optional)*	
Name of maternity care provider (if different than above):	Are you planning to birth at home or at a hospital? ☐ yes ☐ no If at a hospital, name of facility:		
How many months pregnant were you at your first prenatal visit? ☐ 1-3 months ☐ 4-6 months ☐ 7-9 months ☐ Have not had a first visit			
Are you attending, or planning to take prenatal education/classes? ☐ yes ☐ no Comment:			
Are you going to a pregnancy support program in your community? ☐ yes ☐ no Comment:			
If you answered yes to the above questions: What program(s) are you enrolled in?			
Are you interested in free text messages through the SmartMom Prenatal Education Texting Program? ☐ yes ☐ no *If yes to this question:* Text 'Northern' to 12323 or visit www.smartmomcanada.ca and click Enroll Now.			
INFORMATION ABOUT YOU			
Do you have any medical concerns or questions about your pregnancy? ☐ yes ☐ no			
What is your ethnic background?	Are you planning to breastfeed? ☐ yes ☐ no Comment:		
Have you and/or your children had cavities within the past year or need any teeth repaired? ☐ yes ☐ no			
Do you have someone to talk to when you have worries? ☐ yes ☐ no ☐ sometimes Comment:			
Who is in your personal support system? ☐ spouse/partner ☐ family ☐ friends/peer ☐ social services Comment:			
Did you finish high school? ☐ yes ☐ no Highest level of education:			
Do you have a safe place to live? ☐ yes ☐ no Comment:			
How many different places have you lived in the last 2 years? ☐ 1 ☐ 2-3 ☐ >3 Comment:			
Do you have enough of the kinds of foods you want to support your pregnancy? ☐ Always ☐ Sometimes ☐ Never Comment:			
Do you find it hard to live on the money you make? ☐ yes ☐ no Comment:			
Do you have someone to help you with (check all that apply): ☐ labour support ☐ childcare ☐ transportation ☐ Other:			
Do you have a history of depression, anxiety, or other mental health concerns? ☐ yes ☐ no Comment:			
During the past month, have you often felt down, depressed or hopeless? ☐ yes ☐ no Comment:			
During the past month, have you often lost interest in doing things? ☐ yes ☐ no Comment:			
Have you taken any medications in pregnancy? ☐ prescription ☐ over-the-counter ☐ herbal Comment:			
Are you taking a prenatal vitamin with folic acid, iron, and vitamin d? ☐ daily ☐ most days ☐ less then half the time ☐ rarely or never Comment:			
Have you used any of the following substances in pregnancy? ☐ alcohol ☐ cannabis ☐ tobacco ☐ e-cigarettes/vapour ☐ other substances Comment:			
Are you exposed to second or third-hand smoke, vapour, or other exhaled products in the house or car? ☐ yes ☐ no Comment:			
Have you used any substances in the last 6 months? ☐ yes ☐ no Comment:			
Have you used any substances in the last 7 days? ☐ yes ☐ no Comment:			
If you answered yes to above questions: What are your thoughts around quitting or reducing use? ☐ yes ☐ no Comment:			
Is there substance use by others in the home? ☐ yes ☐ no Comment:			
If you answered yes to above questions: Do you have access to a naloxone kit? ☐ yes ☐ no Comment:			
PRIMARY CARE NURSE COMPLETES THIS SECTION			
Name of PCN:	Health unit/primary care nurse:	Need for enhanced prenatal services ☐ yes ☐ no Notes:	
_____ Signature of PCN	_____ Date signed (y/m/d)		