

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.



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.



#healthynorth

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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.



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? <input type="checkbox"/> yes <input type="checkbox"/> no	Was this pregnancy planned? <input type="checkbox"/> yes <input type="checkbox"/> no	
<i>If you answered no to the above question:</i> Have you given birth to other children? <input type="checkbox"/> yes <input type="checkbox"/> 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? <input type="checkbox"/> home <input type="checkbox"/> cell	Is it ok to leave a voicemail/text message? <input type="checkbox"/> yes <input type="checkbox"/> no	
<i>If you do not have a phone:</i> 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? <input type="checkbox"/> yes <input type="checkbox"/> no If at a hospital, name of facility:	
How many months pregnant were you at your first prenatal visit? <input type="checkbox"/> 1-3 months <input type="checkbox"/> 4-6 months <input type="checkbox"/> 7-9 months <input type="checkbox"/> Have not had a first visit		
Are you attending, or planning to take prenatal education/classes? <input type="checkbox"/> yes <input type="checkbox"/> no Comment:		
Are you going to a pregnancy support program in your community? <input type="checkbox"/> yes <input type="checkbox"/> no Comment:		
<i>If you answered yes to the above questions:</i> What program(s) are you enrolled in?		
Are you interested in free text messages through the SmartMom Prenatal Education Texting Program? <input type="checkbox"/> yes <input type="checkbox"/> no <i>If yes to this question:</i> 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? <input type="checkbox"/> yes <input type="checkbox"/> no	Are you planning to breastfeed? <input type="checkbox"/> yes <input type="checkbox"/> no Comment:
What is your ethnic background?	Are you planning to breastfeed? <input type="checkbox"/> yes <input type="checkbox"/> no Comment:
Have you and/or your children had cavities within the past year or need any teeth repaired? <input type="checkbox"/> yes <input type="checkbox"/> no	Do you have someone to talk to when you have worries? <input type="checkbox"/> yes <input type="checkbox"/> no sometimes Comment:
Do you have someone to talk to when you have worries? <input type="checkbox"/> yes <input type="checkbox"/> no sometimes Comment:	Who is in your personal support system? <input type="checkbox"/> spouse/partner <input type="checkbox"/> family <input type="checkbox"/> friends/peer <input type="checkbox"/> social services Comment:
Did you finish high school? <input type="checkbox"/> yes <input type="checkbox"/> no Highest level of education:	Did you finish high school? <input type="checkbox"/> yes <input type="checkbox"/> no Comment:
Do you have a safe place to live? <input type="checkbox"/> yes <input type="checkbox"/> no Comment:	Do you have a safe place to live? <input type="checkbox"/> yes <input type="checkbox"/> no Comment:
How many different places have you lived in the last 2 years? <input type="checkbox"/> 1 <input type="checkbox"/> 2-3 <input type="checkbox"/> >3 Comment:	Do you have enough of the kinds of foods you want to support your pregnancy? <input type="checkbox"/> Always <input type="checkbox"/> Sometimes <input type="checkbox"/> Never Comment:
Do you find it hard to live on the money you make? <input type="checkbox"/> yes <input type="checkbox"/> no Comment:	Do you find it hard to live on the money you make? <input type="checkbox"/> yes <input type="checkbox"/> no Comment:
Do you have someone to help you with (check all that apply): <input type="checkbox"/> labour support <input type="checkbox"/> childcare <input type="checkbox"/> transportation <input type="checkbox"/> Other:	Do you have a history of depression, anxiety, or other mental health concerns? <input type="checkbox"/> yes <input type="checkbox"/> no Comment:
Do you have a history of depression, anxiety, or other mental health concerns? <input type="checkbox"/> yes <input type="checkbox"/> no Comment:	During the past month, have you often felt down, depressed or hopeless? <input type="checkbox"/> yes <input type="checkbox"/> no Comment:
During the past month, have you often felt down, depressed or hopeless? <input type="checkbox"/> yes <input type="checkbox"/> no Comment:	During the past month, have you often lost interest in doing things? <input type="checkbox"/> yes <input type="checkbox"/> no Comment:
Have you taken any medications in pregnancy? <input type="checkbox"/> prescription <input type="checkbox"/> over-the-counter <input type="checkbox"/> herbal Comment:	Have you taken any medications in pregnancy? <input type="checkbox"/> prescription <input type="checkbox"/> over-the-counter <input type="checkbox"/> herbal Comment:
Are you taking a prenatal vitamin with folic acid, iron, and vitamin d? <input type="checkbox"/> daily <input type="checkbox"/> most days <input type="checkbox"/> less than half the time <input type="checkbox"/> rarely or never	Are you taking a prenatal vitamin with folic acid, iron, and vitamin d? <input type="checkbox"/> daily <input type="checkbox"/> most days <input type="checkbox"/> less than half the time <input type="checkbox"/> rarely or never
Comment:	Comment:
Have you used any of the following substances in pregnancy? <input type="checkbox"/> alcohol <input type="checkbox"/> cannabis <input type="checkbox"/> tobacco <input type="checkbox"/> e-cigarettes/vapour <input type="checkbox"/> other substances	Have you used any of the following substances in pregnancy? <input type="checkbox"/> alcohol <input type="checkbox"/> cannabis <input type="checkbox"/> tobacco <input type="checkbox"/> e-cigarettes/vapour <input type="checkbox"/> other substances
Comment:	Comment:
Are you exposed to second or third-hand smoke, vapour, or other exhaled products in the house or car? <input type="checkbox"/> yes <input type="checkbox"/> no	Are you exposed to second or third-hand smoke, vapour, or other exhaled products in the house or car? <input type="checkbox"/> yes <input type="checkbox"/> no
Comment:	Comment:
Have you used any substances in the last 6 months? <input type="checkbox"/> yes <input type="checkbox"/> no Comment:	Have you used any substances in the last 6 months? <input type="checkbox"/> yes <input type="checkbox"/> no Comment:
Have you used any substances in the last 7 days? <input type="checkbox"/> yes <input type="checkbox"/> no Comment:	Have you used any substances in the last 7 days? <input type="checkbox"/> yes <input type="checkbox"/> no Comment:
<i>If you answered yes to above questions:</i> What are your thoughts around quitting or reducing use? <input type="checkbox"/> yes <input type="checkbox"/> no	<i>If you answered yes to above questions:</i> What are your thoughts around quitting or reducing use? <input type="checkbox"/> yes <input type="checkbox"/> no
Comment:	Comment:
Is there substance use by others in the home? <input type="checkbox"/> yes <input type="checkbox"/> no Comment:	Is there substance use by others in the home? <input type="checkbox"/> yes <input type="checkbox"/> no Comment:
<i>If you answered yes to above questions:</i> Do you have access to a naloxone kit? <input type="checkbox"/> yes <input type="checkbox"/> no Comment:	<i>If you answered yes to above questions:</i> Do you have access to a naloxone kit? <input type="checkbox"/> yes <input type="checkbox"/> no Comment:

PRIMARY CARE NURSE COMPLETES THIS SECTION

Name of PCN:	Health unit/primary care nurse:	Need for enhanced prenatal services <input type="checkbox"/> yes <input type="checkbox"/> no
Signature of PCN	Date signed (y/m/d)	Notes: