KOOWEERUP REGIONAL HEALTH SERVICE
EARLY PARENTING UNIT

Client Assessment Form

Enquiry Date:	G P
Date Client Information Sent:	Other Children/Ages:
Admitting Doctor:	

Parent 1 Full Name:	Occupation:	Married:
Date of Birth:	Country of Birth (State if Aus)	Preferred Language:

Parent 2 Full Name:	Occupation:
Tel No AH: Tel No MB: Partner's Tel No:	Are you an Aboriginal/Torres Strait Islander? ☐ Aboriginal ☐ Torres Strait Island ☐ Aboriginal & Torres Strait Islander ☐ Not Aboriginal or Torres Strait Islander Have you been a patient at Kooweerup Hospital before?
Email address:	
Address:	

	Postcode:	Municipality:
Baby's Full Name: ☐ M ☐ F		Date of Birth:

What other Units have you approached?_____

How did you hear about our E.P.U.?

☐ M & CH Nurse ☐Doctor ☐ Other

Where was the baby delivered:

NURSING PHONE ASSESSMENT:		
Are you using a dummy?	❒ Yes	❒ No
Are you agreeable to using a dummy?	❒ Yes	❒ No
G.P. Name/Address:		
Paediatrician Name/Address:		
MCH Nurse's Name/Address:		
Describe current problem:	Day time waking?	Night time waking?
How long has problem been there:		
What have you already tried to manage problem? ☐ Bassinet		☐ Cot
☐ Own Room	☐ Parent's Room	☐ Co-Sleeping
☐ Awake	☐ Asleep	☐ Rocked
☐ Fed	☐ Wrap	☐ Sleeping Bag
☐ Comforter		
Alcohol Intake:	Cigarettes per day:	

EPU – Client Assessment Form

Previous Pregnancies and Breast-Feeding History:		
Pre-Pregnancy, Antenatal, Pregnancy History:		
Delivery Type:	Length Labour:	
Birth Complications (Mother/Baby):		
Breast Feeding History:		
Baby Apgars:	Birth Weight:	Current Weight:
Baby's health since birth – illness, colic, reflux, treatments:		
Immunisation up to date:	Medication:	
Development Assessment:		
Temperament (parent's words):		
Feeding: ☐ B/F		
☐ Formula		
☐ Solids		
Feelings about Parenting:		
Current level of support (family/partner):		
Relationship issues/recent significant family issues/feeling afraid at home (e.g. any physical, sexual or emotional abuse):		
Career/Work/Childcare Issues:		
Allergies/Food Tolerance/Asthma Mother:		
Allergies/Food Tolerance/Asthma Father:		
Allergies/Food Tolerance/Asthma Children:		
Do you or your baby have any special food requirements: ❒ YES ❒ NO ***If yes, please complete "Special Dietary Form"***		
General Health History:		
Sleep Pattern:		
Depression – Family History:		
Depression, Anxiety – Client History		
Current Medication:		

Staff Signature _____ Date:_____

LOCATED PROMPT REVIEWED: July 2023