THE BAYS

The Bays Healthcare Group
Caring for the Peninsula

Maternity admission forms

Congratulations and thank you for choosing to give birth to your baby at The Bays.

To ensure a smooth booking process, please read the following information carefully.

Please complete all the enclosed forms and phone the hospital on 5975 2009 to book a phone interview appointment with one of our midwives. During your appointment the midwife will review your documentation with you, inform you about the admission process and answer any other questions you may have.

It may be faster and easier for you to fill in the form online. Visit the hospital website **www.thebays.com.au/hospital/our-hospital** and click on the **Patient Admission Portal** link located in Downloads and Links. By completing your admission online, some of this information will be retained for future admissions and will only require updating.

Booking paperwork needs to be returned to The Bays reception prior to your phone interview.

Financial information is overleaf.

On your admission day, make sure you bring all of your current medications with you in their original packaging. If you have a medication list from your local doctor please bring this with you too.

Maternity unit tours are available. Visit our website to check our current maternity tour options. Bookings are essential.

Please ensure that you read the patient and maternity information brochures enclosed and further information is available at **www.thebays.com.au**

To book your interview appointment phone us on 03 5975 2009

The Bays Hospital
Vale Street | PO Box 483
Mornington VIC 3931
Phone 03 5975 2009
Fax 03 5975 2373
ABN 35 146 117 211 | www.thebays.com.au

Maternity services financial information

Patients with private health insurance

Please ensure you contact your Health Fund to verify your membership entitlements, i.e. all waiting periods served and no exclusions apply on your policy.
A health fund excess may apply which is payable on admission.

Health fund excess may also apply if your baby needs any additional care requiring admission into the Special Care Nursery. Ensure your baby is covered and if an excess is applicable.

The cost of ambulance transfer to another hospital is your responsibility and we recommend you have ambulance cover for yourself and your baby.

Patients without private health insurance and medicare ineligible patients

If you elect to self-fund your stay in hospital there will be fees payable for:

- Birthing suite or theatre fee for Caesarean Section
- Private room fee per day
- Special Care Nursery (if baby needs admission) per day
- Doctor's fees are separate to any hospital costs.

Please call 03 5975 2009 for a quote and fee estimation.

A deposit of $100 is payable at the time of booking and full payment is required at least *one month prior* to your expected birthing date. There is a cancellation fee of $50.

Ambulance charges apply to yourself and your baby and are not the responsibility of The Bays Hospital.

Childbirth sessions

Childbirth sessions are available to all couples booked into The Bays. Session dates will be organised on the day of booking in with the midwife.

Special Care Nursery

The Bays Hospital has a special care nursery for babies who are premature, unwell or have more complex care needs. It is important that you check your health insurance as many single memberships do not cover newborn babies. If not covered, please call 03 5975 2009 for a quote and fee estimation.

THE BAYS

The Bays Healthcare Group Inc

Vale Street, Mornington 3931
Phone 5975 2009
Fax 5975 2373
Email reception@thebays.com.au

PLEASE COMPLETE AND RETURN TO THE HOSPITAL AS SOON AS POSSIBLE TO CONFIRM YOUR ADMISSION
PLEASE USE BLOCK LETTERS

SHADED AREAS FOR OFFICE USE ONLY

MR No

ADMISSION DATE

ADMISSION TIME (24 hour clock)

EXPECTED DATE OF ADMISSION / /

TITLE Mr/Mrs/Miss/Ms/Master/Doctor

Are you of Aboriginal or Torres Strait Islander descent? No ☐ Yes ☐

SURNAME

BIRTH DATE / / **AGE**

GIVEN NAMES

RELIGION (OPTIONAL)

Country of Birth:

PREVIOUS SURNAME

If Australia, **which** state:

SEX M F **MARITAL STATUS**

Are you a financial member of The Bays? Individual ☐ Family ☐

ADDRESS

State Postcode

TELEPHONE Home No. Mobile Work

EMAIL

Medicare No. - - **Card Ref. No** **Valid to** **Please bring in on admission**

☐ Health Care Card ☐ Government Pension Card Number

☐ DVA Pension Card DVA CARD - GOLD ☐ WHITE ☐ Expiry Date

Pharmacy Safety Net No. or Regular Pharmacist

Ambulance Victoria Subscriber? No ☐ Yes ☐ Member No. **(Note: Not all ambulance costs are 100% covered under health insurance)**

Who is funding this admission? **Health Fund** ☐ **Workcover** ☐ **TAC** ☐ **UNINSURED** ☐ **DVA** ☐

Health Fund/Insurance Co. Membership No.

DVA Number

Do you have a special dietary requirement? No ☐ Yes ☐ If yes please specify:

Reason for admission:

ADMITTING DOCTOR/SURGEON

GENERAL PRACTITIONER

PHONE NUMBER

CLINIC NAME AND ADDRESS

NEXT OF KIN / FIRST CONTACT

Name

Address

Relationship Phone No.: Home Mobile/Work

SECOND CONTACT

Name

Relationship Phone No.: Home Mobile/Work

Have you been a patient at this hospital before? No ☐ Yes ☐ → What Year?

PATIENT'S SIGNATURE (Parent or Guardian if applicable)

Signature Date / /

OFFICE USE ONLY

Has the Patient been discharged from another Hospital within the last seven days? No ☐ Yes ☐ Name of Hospital Adm. Date:

Staff Initial: Pre-booking Admission Room

DO NOT WRITE IN MARGIN

PATIENT REGISTRATION

CPFEB2019

MR/001

THE BAYS

The Bays Healthcare Group Inc

PATIENT HISTORY SHEET

MR NUMBER _____

SURNAME _____

GIVEN NAME(S) _____

DATE OF BIRTH _____ GENDER _____

Please fill in if no Patient label available

If you are under the care of any other Medical Specialists please give details below			
	Last review date		Last review date
Physician		Cardiologist	
Vascular Doctor		Diabetes Educator	
Kidney specialist		Respiratory Physician	

HEALTH HISTORY - please tick yes or no to the following	WEIGHT		HEIGHT	
CENTRAL NERVOUS SYSTEM	**No**	**Yes**	**Provide details below**	
Neuromuscular disease ☐ Parkinsons ☐ Multiple Sclerosis ☐ Motor Neurone Disease ☐				
Depression ☐ Mental illness ☐ Anxiety ☐ Panic attacks ☐				
Difficulties with attention span, understanding or problem solving				
Short term memory loss ☐ Confusion ☐ Dementia ☐				
Epilepsy ☐ Fits ☐ Seizures ☐				
Migraines				
CARDIOVASCULAR	**No**	**Yes**	**Provide details below**	
Bleeding disorder ☐ Anaemia ☐ Bleeding problems ☐ Bruise easily ☐				
Heart attack ☐ Heart failure ☐ Angina ☐ Cardiomyopathy ☐				
Artificial heart valve ☐ Implantable Defibrillator ☐ Pacemaker ☐				
Cardiac stents ☐ Cardiac bypass ☐				
Blood pressure problems ☐ Low ☐ Hypertension ☐				
Irregular heart beat ☐ Murmur ☐ Palpitations ☐				
Stroke ☐ Cerebrovascular Accident ☐ TIA ☐				
History of Deep Vein Thrombosis (DVT) ☐ Pulmonary Embolus (PE) ☐				
Vascular disease ☐ Vascular aneurysm ☐				
RESPIRATORY	**No**	**Yes**	**Provide details below**	
Asthma ☐ Bronchitis ☐ COPD ☐ Emphysema ☐ Tuberculosis ☐ Asbestosis ☐				
Do you use home oxygen?				
Sleep apnoea ☐ Disturbed sleep ☐ Snoring ☐				
Do you use a CPAP machine? Do you know the pressure? _____			*Please ensure you bring your CPAP machine to hospital with you*	
GASTROINTESTINAL	**No**	**Yes**	**Provide details below**	
Speech problems ☐ Swallowing problems ☐				
Liver disease ☐ Hepatitis ☐ Jaundice ☐				
Bowel disease ☐ Faecal incontinence ☐				
Gastric reflux ☐ Stomach ulcer ☐ Hiatus hernia ☐				
Have you had gastric banding surgery ☐ Sleeve gastrectomy ☐ Gastric bypass ☐			*If yes, please contact your Anaesthetist*	
Do you have any eating difficulties or special dietary needs?			Specify:	
Did you lose weight in the last 6 months without trying?				
Do you have a decreased appetite?				

DO NOT WRITE IN MARGIN

PATIENT HISTORY SHEET

CPAPR2020

MR/081

HEALTH HISTORY - please tick yes or no to the following			
ENDOCRINE	**No**	**Yes**	**Provide details below**
Do you have diabetes? Type 1 ☐ Type 2 ☐			
Do you manage your diabetes with: Diet ☐ Tablet ☐ Insulin ☐			
Thyroid disease			
RENAL	**No**	**Yes**	**Provide details below**
Kidney disease ☐ Kidney failure ☐ Dialysis ☐			
Bladder problems ☐ Urinary incontinence ☐			
SKIN & MUSCULO-SKELETAL	**No**	**Yes**	**Provide details below**
Rheumatoid arthritis ☐ Osteoarthritis ☐			
Spinal injury ☐ Back pain ☐ Neck pain ☐			
Have you had spinal surgery?			
Do you have any wounds, or breaks on your skin?			
Do you have or have had any pressure injuries / ulcers / bedsores?			
Do you have any implants / prosthesis (eg. hip replacement)?			
MISCELLANEOUS / RISK IDENTIFICATION	**No**	**Yes**	**Provide details below**
Cancer: specify site(s)			
Are you currently undergoing chemotherapy?			Last given: / /
Are you a registered organ donor			
Do you have an Advanced Care Directive ☐ Advanced Care Plan ☐ Enduring Power of Attorney (medical treatment) ☐			If so, please bring a copy of these documents with you
Do you have a spinal cord stimulator			If so, please bring remote into hospital
Blood tests taken for this admission			
Pathology company:			
Blood thinning medication - Warfarin, Plavix, Cartia, Astrix, Iscover, Asasantin, Pradaxa, Xarelto, Eliquis, Brillinta, Effient			Please ensure you bring your medications to hospital with you
Blood thinning medication stopped?			If stopped - when?
Warfarin Pathology Collector: Last INR: Usual Warfarin Dose:			
ECGs / X-rays / CT scans / MRI scans / Ultrasounds been taken for this admission			Please bring with you to hospital
Do you have a fear of falling or are you unsteady on your feet?			
Have you experienced fainting or dizziness in the last 6 months?			
Have you fallen / tripped within the last 6 months?			
Do you use any mobility aids? Eg. Walking stick, frame			Please ensure you bring your mobility aid to hospital with you
Have you ever had an adverse reaction to a blood transfusion or a transfusion of blood products			
Lymphoedema risk ☐ Lymphoedema condition ☐			
Organ failure ☐ Organ transplant ☐			
Any other illness / condition - please specify			
Do you or have you ever smoked? Smoker ☐ Ex-smoker ☐			Daily amount: Date ceased: / /
What is your daily alcohol intake?			
Do you use recreational drugs?			Daily amount: Type: Ceased date: / /
Impaired vision			
Impaired hearing. Please document if hearing aids are with the patient at the time of admission.			
Dentures ☐ Plate ☐ Crowns ☐ Caps ☐ Braces ☐			Upper ☐ Lower ☐ Both ☐
Any special needs during your stay?			
Are you pregnant? How many weeks?			

DO NOT WRITE IN MARGIN

CPAPR2020

THE BAYS

The Bays Healthcare Group Inc

PATIENT HISTORY SHEET

MR NUMBER _____

SURNAME _____

GIVEN NAME(S) _____

DATE OF BIRTH _____ GENDER _____

Please fill in if no Patient label available

If the response to any of the questions BELOW is YES please contact The Bays Hospital Pre-admission Nurse: Phone 5976 5210 prior to your admission date.

	INFECTION CONTROL SCREENING	No	Yes	Provide details below
Carbapenem Resistant Enterobacteriaceae (CRE) and Candida Auris Screening	Have you / the patient ever been informed you have had a multi-resistant organism infection?			
	Have you / the patient been directly transferred from any overseas healthcare facility?			
	Have you / the patient been admitted to any overseas healthcare facility in the past 12 months?			
	Have you / the patient resided in any overseas Residential Aged Care Facility in the past 12 months?			
	Have you / the patient been identified as a Candida auris and /or CRE contact during any hospitilisation?			
	Have you / the patient had a confirmed Candida auris and / or CRE infection?			
Creutzfeldt-Jakob Disease (CJD)	Have you had surgery on the brain or spinal cord that may have included a dura mater graft, prior to 1990?			
	Have you had two or more first degree relatives diagnosed with Creutzfeldt-Jakob Disease (CJD) or other prior disease, where a genetic cause has not been excluded?			
	Have you suffered from a recent (less than 12 months) progressive dementia illness (physical or mental), the cause of which has not been diagnosed / explained?			
	Have you received human pituitary hormones for infertility of human growth hormone for short stature, prior to 1986?			
	Have you been involved in a “Look Back” study for cCJD or in possession of a “Medical in Confidence Letter” regarding risk of cCJD?			
Acute Respiratory Infection	Do you have a fever and / or respiratory symptoms? Cough, sore throat, runny nose			
	Have you had recent contact with a person diagnosed with Acute Respiratory Infection or Acute Respiratory Illness in the last 14 days - seasonal or pandemic			
	Have you travelled to areas of high prevalence for Acute Respiratory Infections - Seasonal or pandemic either overseas or within Australia in the last 14 days			

PREVIOUS PROCEDURES AND SURGERY (If yes, please list below)	Approximate year of surgery
Have you previously had a general anaesthetic? No ☐ Yes ☐	List any reactions below

DO NOT WRITE IN MARGIN

CPAPR2020

MEDICATION SUMMARY

While you are a patient in our hospital we will endeavour to ensure that all medications prescribed for you are safe and appropriate. It is important to have an accurate record of all medication that you are already taking, or have recently ceased. **Please complete the following list taking care to include all prescribed, over the counter, herbal and vitamin products.** Please also include all eye drops, patches, natural medicines or topical products. If you have any problems completing the list below please contact your Local Doctor (GP) or Local Pharmacy for assistance.

PLEASE BRING TO HOSPITAL A PRINTED LIST OF ALL MEDICATION PRESCRIBED TO YOU BY YOUR DOCTOR AND ALL CURRENT MEDICATIONS IN THE ORIGINAL PACKAGING IF AVAILABLE

Do you use a Dose Administration Aid eg. Webster Pack/Sachets/Pill Box? ☐ No ☐ Yes Which Pharmacy? _____

Current Medication	Strength	Dose	Reason for taking?	Taking for how long?
				2 years

Medication STOPPED in the past 2 weeks	Strength	Dose	Reason for taking?	When/why stopped?

Charges for medication provided during your stay in hospital will be billed to your pharmacy account according to the agreement between your Private Health Fund and the Hospital. Not all pharmacy items will be covered by your health fund. In this case a pharmacy account will be presented to you on discharge.

DO YOU HAVE ANAPHYLAXIS? ☐ **Yes** ☐ **No**
If yes, what causes the **ANAPHYLAXIS?** _____
(PLEASE ENSURE YOU BRING YOUR EPIPEN AND ANAPHYLACTIC MANAGEMENT PLAN TO HOSPITAL WITH YOU)

Do you have any ALLERGIES or ADVERSE REACTIONS to any medications, latex, tapes, skin preps, antiseptics or other? ☐ **Yes** ☐ **No**
If yes, please state the name and the reaction _____

DISCHARGE PLANNING	No	Yes	Provide details below
Do you live alone?			
Do you have someone to care for you after discharge?			
Name:	Contact number:		Relationship:
Are you solely responsible for the care of another person at home?			
Do you currently use any community or nursing services?			
Do you require assistance with daily living?			
Do you have any concerns regarding how you will manage at home after discharge?			
Where do you plan to go following discharge?	Home		Other:
Who is picking you up?	Contact number:		

The information I have provided here is accurate and complete to the best of my knowledge

Patient signature:		**Date:**
Reviewed by Pre-admission Nurse - name and signature:	**Date:**	**Screen** ☐ **Phone R/V** ☐ **Clinic R/V** ☐
Admitting Nurse name and signature:		**Date:**

DO NOT WRITE IN MARGIN

CPAPR2020

THE BAYS

The Bays Healthcare Group Inc

PAEDIATRIC SERVICES & CHARGES FOR PATIENTS

UR NUMBER _____

SURNAME _____

GIVEN NAMES _____

DATE OF BIRTH _____ SEX _____

Please fill in if no Patient Label available

It is important that expectant parents understand the services provided by paediatricians and the cost of those services.

The paediatrician's fee is not included in the fee raised by your obstetrician or by the hospital.

In some circumstances, for example, if you have a caesarean section or if there is concern about your baby after the birth, your obstetrician may call on the services and expertise of a paediatrician.

That assistance might be required at any time of the day or night.

Specialist paediatricians provide an 'on call' roster at The Bays. If your paediatrician is not immediately available out of normal hours, you may initially see one of the other paediatricians who works at the hospital.

The paediatricians may have slightly different fee structures. For more information on these different fee structures you will need to contact the individual paediatrician.

Please note:-

1. A proportion of those fees are eligible for rebate through Medicare.
2. Your private health fund may also contribute to those fees if you have 'Family Cover' and if your baby is admitted as a patient in its own right.*
3. You may be required to meet full paediatrician costs and then pursue rebates from Medicare and your health fund.

* If the baby does not have a significant medical problem, the health fund considers the baby to be a boarder, not a hospital inpatient.

Please contact the Maternity Unit at The Bays Hospital or your paediatrician if you have any queries about these arrangements.

I (name) _____
hereby acknowledge that I understand the contents of this document and accept full responsibility for the payment of fees for paediatric services that my baby might require.

Signed _____

Full Name (print) _____

Date _____

DO NOT WRITE IN MARGIN

CPFEB2019

PAEDIATRIC SERVICES & CHARGES FOR PATIENTS MR/141

THE BAYS

The Bays Healthcare Group Inc

USE OF MOBILE PHONES & RECORDING DEVICES IN MATERNITY for Patients & Support Persons

UR NUMBER _____

SURNAME _____

GIVEN NAMES _____

DATE OF BIRTH _____ SEX _____

Please fill in if no Patient Label available

The Bays Healthcare Group recognises special and unique moments arise whilst in hospital which you or your family and friends may wish to capture on film.

For the safety and privacy of our patients, staff members and medical personnel, we do not allow mobile, video or sound recording devices to be used in the birthing rooms, theatre or special care nursery.

Single shot devices which do not record sound are permissible, if agreed to by the care team members present at the time.

Provided the privacy of other patients and staff members is not compromised, film and sound may be recorded in the privacy of your own room.

Signature _____ Signature of Support Person _____

Print Name of Patient _____ Print Name of Support Person _____

Date _____ Date _____

DO NOT WRITE IN MARGIN

CPAUG2020

USE OF MOBILE PHONES & RECORDING DEVICES IN MATERNITY for Patients & Support Persons

MR/151

THE BAYS

The Bays Healthcare Group Inc

OBSTETRIC BOOKING FORM

MR NO. _____

SURNAME _____

GIVEN NAME(S) _____

DATE OF BIRTH _____ GENDER _____

HOSPITAL USE ONLY Please fill in if no Patient label available

PLEASE COMPLETE BOTH SIDES & BRING BACK TO HOSPITAL WHEN BOOKING IN

Date of last normal menstrual period (LNMP): Due date by menstrual date / ultrasound:

Preferred name: Partner's name:

Obstetrician: Blood Group: ----------

Date of 1st visit to GP/O&G relating to pregnancy: ___/___/___ Gestation - 1st visit to GP/O&G ---------- weeks

Pre Pregnancy weight: ---------- Height: ---------- Is this a twin pregnancy? ☐ No ☐ Yes

Have you had any pregnancy related problems during this pregnancy (eg. gestational diabetes / pregnancy induced hypertension)? ☐ No ☐ Yes

If yes, please specify (including treatment): ----------

Do you have a history of depression or anxiety? ☐ No ☐ Yes

If yes, please specify (including treatment): ----------

Edinburgh score for this pregnancy: ---------- Weeks gestation completed: ----------

(Midwife to complete)

Plan for vaginal birth after a previous caesarean ☐ N/A ☐ Yes ☐ No

Do you intend to have pre-natal classes? ☐ Yes ☐ No

How do you plan to feed your baby? ☐ Breast ☐ Bottle ☐ Both ☐ Undecided

Have you had breast surgery (eg. breast reduction) or issues that could impact breast feeding ☐ Yes ☐ No

If yes, please specify: ----------

Previous breast feed experiences / services accessed ☐ No ☐ Yes

If yes, please specify: ----------

If you have any concerns you can discuss at booking-in with your midwife and/or request to see the Lactation consultant prior to the birth.

Lactation Consultant review requested ☐ Yes ☐ No ☐ Declined

Investigations/Procedures:-

Ultrasound	☐ Yes	☐ No	If yes, how many weeks:		
Maternal Serum Screening	☐ Yes	☐ No	Non Invasive Perinatal Testing (NIPT)	☐ Yes	☐ No
CVS	☐ Yes	☐ No	Amniocentesis	☐ Yes	☐ No
Assisted conception / IVF	☐ Yes	☐ No			

Please specify if yes to IVF: ----------

DO NOT WRITE IN MARGIN

OBSTETRIC BOOKING

CPSEP2020

MR/288

THE BAYS

The Bays Healthcare Group Inc

OBSTETRIC BOOKING FORM

MR NO. _____

SURNAME _____

GIVEN NAME(S) _____

DATE OF BIRTH _____ GENDER _____

HOSPITAL USE ONLY Please fill in if no Patient label available

Please include all details of previous pregnancies, including miscarriages

GRAVIDA: **PARITY:**

Date	No. of weeks of pregnancy	Place of Birth	Type of Birth (Vaginal/Forceps/ Casesarean)	Length of Labour	Pain relief during labour	Gender	Weight	Breast/ Bottle/ Both	Name of child
eg. 1.1.2018	38	The Bays	Forceps	8 hrs	Pethidine, Epidural	M	3500	Both	Scott

Did you have any complications during your previous pregnancies (eg. gestational diabetes / pregnancy induced hypertension? ☐ No ☐ Yes If yes, please specify (including treatment): ----------

Did you have any complications after the birth of your previous child(ren) (eg. post partum haemorrhage)? ☐ No ☐ Yes Please specify: ----------

Was your previous baby admitted to Special Care Nursery? ☐ No ☐ Yes
If yes, please specify: ----------

Lifestyle

Does your partner smoke? ☐ No ☐ Yes
If Yes, would you like a referral for QUIT information ☐ No ☐ Yes

If you have ceased smoking was it: before 20 weeks gestation ☐ No ☐ Yes
: after 20 weeks gestation ☐ No ☐ Yes

Do you or your partner have a family history of:

Multiple births ☐ Yes ☐ No Diabetics ☐ Yes ☐ No
High blood pressure ☐ Yes ☐ No

Is the father of the baby of Aboriginal or Torres Strait Islander descent: ☐ Yes ☐ No

Genetic disorders ☐ Yes ☐ No
If yes, please specify: ----------

Other ☐ Yes ☐ No
If yes, please specify: ----------

PATIENT'S SIGNATURE:

Midwife's Signature: **Midwife's Name:** **Date:**

DO NOT WRITE IN MARGIN

THE BAYS

The Bays Healthcare Group Inc

EDINBURGH PRE & POST NATAL DEPRESSION SCALE CHECKLIST

UR NUMBER _____

SURNAME _____

GIVEN NAMES _____

DATE OF BIRTH _____ SEX _____

Please fill in if no Patient Label available

We would like to know how you have been feeling in the past week. **Please indicate which of the following comes closest to how you have felt in the past week**, not just how you feel today. Please **tick one box** for each question, which is the closest to how you have felt in the **past seven days**.

Please fill in prior to booking in appointment

1. I have been able to laugh and see the funny side of things.	☐ As much as I always could ☐ Not quite so much now ☐ Definitely not so much now ☐ Not at all
2. I have looked forward with enjoyment to things.	☐ As much as I ever did ☐ Rather less than I used to ☐ Definitely less than I used to ☐ Hardly at all
3. I have blamed myself unnecessarily when things went wrong.	☐ Yes, most of the time ☐ Yes, some of the time ☐ Not very often ☐ No, never
4. I have been anxious or worried for no good reason.	☐ No, not at all ☐ Hardly ever ☐ Yes, sometimes ☐ Yes, very often
5. I have felt scared or panicky for no very good reason.	☐ Yes, quite a lot ☐ Yes, sometimes ☐ No, not much ☐ No, not at all
6. Things have been getting on top on me.	☐ Yes, most of the time I haven't been able to cope at all ☐ Yes, sometimes I haven't been coping as well as usual ☐ No, most of the time I have coped quite well ☐ No, I have been coping as well as ever
7. I have been so unhappy that I have had difficulty sleeping.	☐ Yes, most of the time ☐ Yes, sometimes ☐ Not very often ☐ No, not at all
8. I have felt sad or miserable.	☐ Yes, most of the time ☐ Yes, quite often ☐ Not very often ☐ No, not at all
9. I have been so unhappy that I have been crying.	☐ Yes, most of the time ☐ Yes, quite often ☐ Only occasionally ☐ No, never
10. The thought of harming myself has occurred to me.	☐ Yes, quite often ☐ Sometimes ☐ Hardly ever ☐ Never

DO NOT WRITE IN MARGIN

Source Cpx JL: Holden JM Sagovsky R (1987) Detection of postnatal depression: development of the 10 item Edinburgh postnatal depression scale. Brit J Psychiatry 150:782-86. Developed as the Edinburgh Postnatal depression Scale and validated for use in both pregnancy and the postnatal period to asses for possible depression and anxiety.