

HAPŪ WĀNANGA

Māori pregnancy, childbirth and parenting programme

REGISTRATION FORM*

Send completed forms to: hapuwananga@nmdhb.govt.nz

MOTHER'S DETAILS:

FIRST NAME: _____ SURNAME: _____

DATE OF BIRTH: _____

WHĀNAU ADDRESS: _____ TOWN _____

CONTACT PHONE: _____ OTHER CONTACT: _____

PARTNER/WHĀNAU SUPPORT: _____

PĒPI (BABY) ETHNICITY: NZ Māori _____ (iwi/hapū)

Pacific _____

NZ European

Other _____

HEALTH INFORMATION:

NHI: _____ (if known) GP: _____ LMC: _____

Estimated Date of Delivery (EDD): _____

Parity (Number of pregnancies >20weeks) _____

Smokefree Smoking Quit Smoking Referred to Pēpi First quit support

Other relevant information (support networks, general health and wellbeing)

SELF REFERRED or DETAILS OF REFERRER:

Maternal consent obtained for registration: yes no

Referrer's Name: _____

Organisation/ Role: _____

Email: _____ Phone: _____ Date: _____

Please note: This form is a registration of interest. Te Waka Hauora (TWH) will contact whānau to confirm attendance. **Places are limited, TWH may have to prioritise whānau further along in pregnancy or as individual circumstance requires. Ngā mihi.*

ADMINISTRATION USE

Location/date:

Contacted/Confirmed: yes no

Whānau support:

Dietary requirements:

Transport required:

