

Pregnancy Notification Form (Post-delivery Pregnancy Notification Form)

*Please fill out the bold area below.

		Maternity Passbook #			
Kana Syllables		DOB(dd/mm/yyyy)		(Age:)	
Mother's Name		Personal ID number "My-number"			
Address		Hachioji City		Occupation	
Phone		(Telephone/Mobile)			
Weeks of Pregnancy	Weeks (Months)	Expected Date of Delivery (Date of Delivery)	(dd/mm/yyyy)		
Health checkup regarding STDs (Blood test)	<input type="checkbox"/> Already tested <input type="checkbox"/> Not yet	Health checkup regarding tuberculosis (Chest X-ray)	<input type="checkbox"/> Already tested <input type="checkbox"/> Not yet		
Have you already been diagnosed by a physician or midwife?	<input type="checkbox"/> Yes		<input type="checkbox"/> No		
	Facility Name Address Name *State the name of hospital/medical institution/clinic/maternity center in the section above.				
Number of Pregnancy	<input type="checkbox"/> The first time • <input type="checkbox"/> () time (s)				
I hereby notify you as above. (dd/mm/yyyy) <p style="text-align: center;">Informant _____</p> (State your relationship to the woman if you are submitting this form on her behalf) To the Mayor of Hachioji					

*Please complete the Power of attorney if you are entrusting this form to someone else.

Power of Attorney	
Attorney's address _____ name _____ relationship to the mother ()	Mother's address _____ name _____
I hereby give permission for the person above to submit this form on my behalf using "my-number".	

*The following is a questionnaire for pregnant women. Please tell us your condition and feelings.

We aim to support you from the start of your pregnancy to helping you raise your child. Please note that this information will be managed by Health and Welfare Center and will not be used for purposes other than our delivery and childcare services. Your cooperation is greatly appreciated.

- Is everything going well with your pregnancy? Yes / No (Reason:)
- How do you feel about this pregnancy? (Multiple choices allowed)
 (a) Happy (b) Unhappy (c) Anxious (d) Others
 Tell us more: ()
- Do you have someone to help you with this pregnancy and delivery? Yes / No
 If yes, who is it? (My partner / parent / brother or sister / friend / Other _____)
- Do you wish to receive advice from our health nurse regarding your pregnancy or delivery?
 No
 Yes Tell us more: ()
 Please provide someone who can respond to our call in Japanese.
 Phone: - - Name: Relationship: _____

*Please note that our health nurse may visit you according to the information on this survey form.

25.08

*Please complete the following section if you are submitting this form as a post-delivery pregnancy notification.			
Kana Syllables		DOB	(dd/mm/yyyy)
Child's Name			(Age: year (s) month (s))

..... FOR CITY USE ONLY (DO NOT WRITE)

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|--------------------------------------|------------------------------|-------------------------------|------------------------------|-----------------------------|-----------------------------|-----------------------------|
| <input type="checkbox"/> 大横保健福祉センター | <input type="checkbox"/> 市民課 | <input type="checkbox"/> 南口総合 | <input type="checkbox"/> 石川 | <input type="checkbox"/> 加住 | | |
| <input type="checkbox"/> 東浅川保健福祉センター | <input type="checkbox"/> 浅川 | <input type="checkbox"/> 横山 | <input type="checkbox"/> 館 | <input type="checkbox"/> 元八 | <input type="checkbox"/> 恩方 | <input type="checkbox"/> 川口 |
| <input type="checkbox"/> 南大沢保健福祉センター | <input type="checkbox"/> 由木 | <input type="checkbox"/> 由木東 | <input type="checkbox"/> 南大沢 | <input type="checkbox"/> 北野 | <input type="checkbox"/> 由井 | |