

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				DOB		(dd/mm/yyyy)		(Age:)	
Address		Hachioji City				Occupation			
Phone		(Telephone/Mobile)							
Weeks of Pregnancy	(Weeks Months)	Expected 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		<input type="checkbox"/> No
			*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)						
<p>I hereby notify you as above.</p> <p>(dd/mm/yyyy)</p> <p style="text-align: center;">Informant _____</p> <p style="text-align: center;">(State your relationship with the woman if you are submitting this form on behalf of her)</p> <p>To the Mayor of Hachioji</p>									

*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				DOB		(Age: year (s) month (s))	

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

We aim to support you from the start of pregnancy to help 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 kind cooperation is greatly appreciated.

1. Is everything going well with your pregnancy? Yes / No (Reason:)
2. How do you feel about this pregnancy? (Multiple choices allowed)
 (a) Happy (b) Unhappy (c) Anxious (d) Others
 Tell us more: ()
3. 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 / Others _____)
4. Do you wish to receive advice from our health nurse regarding your pregnancy or delivery?
 No
 Yes Tell us more: ()

◆Please indicate 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.

-FOR CITY USE ONLY (DO NOT WRITE).....
- | | | | | |
|--------------------------------------|------------------------------|-------------------------------|------------------------------|-----------------------------|
| <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"/> 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"/> 恩方 | <input type="checkbox"/> 川口 |
| | | | <input type="checkbox"/> 由井 | |