

# Birth History

Patient ID: \_\_\_\_\_ Ward: \_\_\_\_\_ Attending doctor: \_\_\_\_\_

Admission number: \_\_\_\_\_ Room No./Bed: \_\_\_\_\_ Date of admission: \_\_\_\_\_ Department: \_\_\_\_\_

<b>Bold-framed fields to be filled in by patient</b>	Date and place of civil marriage:		Maiden name:	
	Last name:	Address/Street/No.:		Nationality:
	First name, degree:	ZIP code/City:		Phone number:
	Date/place of birth:	Marital status:	Religion:	E-mail address:
	Profession:	Employer:	Diagnosis at admission:	

## Private contact person

Last name:	Address/Street/No.:	Phone number:
First name, degree:	ZIP code/City:	Work phone number:

## Insurance details

Social insurance:	Insurance No.:
If co-insured : main person insured (first and last name, degree):	Insurance No.:
Address/Street/No.:	Family relationship:
Employer:	Profession:
Additional insurance:	Policy No.:

NOTES:

BIRTH: \_\_\_\_\_

Name of child: \_\_\_\_\_

Discharged:	Transferred/Hospital:
Discharged before giving birth:	
Time:	Time:

**Completed and signed birth history**  
**Attending doctor:**

## Blood sample for extraction of stem cells

Tissue bank: \_\_\_\_\_

Cord blood  Cord tissue

Documentation (LC7450): \_\_\_\_\_

Blood draw (LC7451): \_\_\_\_\_

Anamnesis (LC7452): \_\_\_\_\_

Reimbursement of extraction facility:(LC7453-creditor000995)

I acknowledge that the Goldenes Kreuz Private Hospital as a "mobile collection team" cannot assume any liability for the successful outcome of any extracted cord blood or tissue.

Signature: \_\_\_\_\_

## Completeness of birth documentation

- Patient information / patient information sheet
- Medical report
- Discharge letter
- Surgery report epidural
- Birth history signed by attending doctor
- Birth report signed by attending doctor

Additional information in case of surgery:

- Anesthesia information
- Surgery report

**The birth history is confirmed to be complete.**

Head of Department: \_\_\_\_\_

**MEDICAL FEES**

(please use capitals letters)

Attending doctor during birth:	_____	_____
Midwife:	_____	_____
Anesthesia:	_____	_____
1 <sup>st</sup> assistant doctor:	_____	_____
2 <sup>nd</sup> assistant doctor:	_____	_____
Surgical nurse:	_____	_____
Surgical assistant:	_____	_____
Observation ward:	_____	_____
1 <sup>st</sup> medical consultation:	_____	_____
2 <sup>nd</sup> medical consultation:	_____	_____
1 <sup>st</sup> pediatrician:	_____	_____
2 <sup>nd</sup> pediatrician:	_____	_____
Pediatric nurse:	_____	_____
Nurses ward 2/3:	_____	_____
Administration:	_____	_____

**MEDICATION GIVEN IN OPERATING/DELIVERY ROOM:**

_____	_____
_____	_____
_____	_____
_____	_____

**Details of 2nd parent**

Last name:		First name, degree:		Maiden name (if applicable):	
Address/Street/No.:				ZIP code/City:	
Date/place of birth:		Nationality:	Religion:	Profession:	
Employer:				Phone number:	
Social insurance:				Insurance No.:	

Please complete this form and return it to us no later than during your stay at our maternity ward.

**Thank you!**