PATIENT INFORMATION AND CONSENT FORM

Title: _____ First Name: _____ Surname: _____

DOB: _____ /_____ /_____ Height: _____ Weight: _____

Address: _____

Suburb: _____ Postcode: _____

Postal Address (if different): _____

Phone: Home _____ Work _____ Mobile _____

Email address: _____

Emergency Contact Name: _____

Relation: _____ Emergency contact Phone: _____

Medicare Card No: _ _ _ _ _ _ _ _ _ _ _ _ Ref No. (Next to your name) _____ Expiry Date: __ / __

Private Health Fund: _____ Membership No: _____

What level of cover do you have (Please circle)?

GOLD (TOP) SILVER (MIDDLE) BRONZE (BASIC) EXTRAS ONLY

DVA No: _____ DVA Card Colour: GOLD / WHITE

DVA Accepted Condition (White card only): _____

Aged Pension Card? Y/ N Pension Card No: _____

Usual GP Name: (if different from referrer): _____

GP Practice Name / Address: _____

_____

Phone No: _____

Workcover: YES / NO CTP Claim: YES / NO

Claim No: _____ Injury/Accident Date: _____ /_____ /_____

Insurer Name: _____ EMAIL: _____

COLLECTION OF INFORMATION:

This medical practice collects information from you for the primary purpose of providing quality health care. We require you to provide us with your personal details and medical history so that we may properly assess, diagnose, and manage your health care needs. In addition to this we may require you to undergo ultrasound imaging for diagnostic purposes.

I give consent for ultrasound imaging to be performed ☐ (Please tick)

I give consent for my records to be uploaded to My Health Record YES / NO (Please circle)

Please advise staff if you would like a copy of our ultrasound service information.

(Please note: Any no show to appointments will incur a $150 rebooking fee)

Name: _____ Date: _____ /_____ /_____

Signature: _____

PATIENT INFORMATION AND CONSENT FORM

Medical History: (Please tick all that apply)

	Asthma/Breathing difficulties		Phlebitis or blood clots		Cancer
	Strokes		Radiation/Chemotherapy		Thyroid issues
	Migraine/Severe Headaches		Kidney Infections		High Blood Pressure
	Heart Attack		AIDS/HIV		Diabetes
	Cardiac stent		Kidney Stone / infections		Arthritis
	High Cholesterol		Stomach Ulcers		Tuberculosis
	Hepatitis				

Other: _____

Previous Surgeries: _____

_____

_____

Previous Investigations:
(Please list the dates and radiology/pathology practice where you may have had the following studies):

MRI: _____

CT Scan: _____

Blood Tests: _____

Vascular Scans/ Ultrasound Doppler: _____

Medications:

(Please list medications you are currently taking including prescription/non-prescription, vitamins, supplements): _____

_____

_____

Medication Allergies: _____

_____

Other Specialists Involved in your care:

(Please list doctors name and profession ie: Cardiologist, Rheumatologist, Renal, Respiratory Specialist):

_____

_____

_____