TAMBORINE MOUNTAIN MEDICAL PRACTICE

PATIENT INFORMATION AND CONSENT FORM

We are committed to providing our patients with the best possible care. To do this it is essential that your health record is kept up to date and accurate.

We would appreciate your assistance by completing the following: (Please Print clearly)

TITLE		☐ Dr ☐ Mr ☐ Mrs ☐ Ms ☐ Miss	
SURNAME			
FIRST NAME		**Middle Name**	
DATE OF BIRTH		**Country of Birth**	
STREET ADDRESS			
SUBURB AND POSTCODE			
POSTAL ADDRESS			
HOME PHONE			
WORK PHONE			
MOBILE PHONE			
EMAIL ADDRESS			
MEDICARE NO.	Ref. No.	#:	Expiry Date:
☐ **DVA GOLD** ☐ **DVA WHITE** (Please tick which card you hold)		#:	Expiry Date:
PENSION CARD NUMBER		#:	Expiry Date:
HEALTH CARE CARD NUMBER		#:	Expiry Date:
PRIVATE HEALTH COVER		Name:	#:
NEXT OF KIN (Name, address and Telephone number)			
RELATIONSHIP TO PATIENT			
EMERGENCY CONTACT (Name, Address and Telephone number of the person we should contact if needed)			
PATIENTS OCCUPATION			
EMPLOYER NAME			
EMPLOYER ADDRESS			
EMPLOYER TELEPHONE NUMBER			
PREVIOUS MEDICAL PRACTICE			
ADDRESS AND PHONE NUMBER			

REMINDER SYSTEMS

Our practice provides our patients with preventive care and early case detection reminders (e.g. immunisations, annual health checks, skin checks and pap smears):

Do you wish to have any relevant health reminders sent to you?	☐ **No**
☐ Yes – by Mail ☐ Yes – by SMS to this mobile no…… ☐ Yes – by this email address……	
If we need to contact you, what is your preferred method of contact?	
☐ Home Phone ☐ Mail ☐ Mobile ☐ Email	
Are there any health issues which you would like to receive information on?	

PATIENT BACKGROUND

Australia is a genuinely multicultural society. To tailor appropriate care, encourage understanding and appreciation between people from different nationalities and backgrounds we ask that you complete to following:

Do you identify as someone from a culturally and/or linguistically diverse background?

- ☐ No
- ☐ Yes - please provide details

To assist with health initiatives – are you an Aboriginal or Torres Strait Islander?

- ☐ No
- ☐ Yes – Aboriginal
- ☐ Yes – Torres Strait Islander
- ☐ Yes – Aboriginal and Torres Strait Islander

YOUR HEALTH HISTORY

Do you have or have you had a history of the following? (please give details in full)

- ☐ Operations
- ☐ Asthma
- ☐ Diabetes
- ☐ Hypertension
- ☐ Chronic Illness
- ☐ Other

Do you have any allergies or are you sensitive to drugs or dressings?

- ☐ No
- ☐ Yes (please give details)

IMMUNISATIONS

Have you had the following immunisations? (list date where appropriate)			
Tetanus Booster	☐ Yes Date:	☐ No	☐ Don't know
Hepatitis B	☐ Yes Date:	☐ No	☐ Don't know
Hepatitis A	☐ Yes Date:	☐ No	☐ Don't know
Influenza	☐ Yes Date:	☐ No	☐ Don't know
Pneumococcal	☐ Yes Date:	☐ No	☐ Don't know
Polio	☐ Yes Date:	☐ No	☐ Don't know

CHILDREN'S IMMUNISATIONS

If completing this form for a child, are their immunisations up to date?

☐ Yes ☐ No

CURRENT MEDICATION

Please list all current medications, including over the counter medications, vitamins and minerals:

FAMILY HISTORY

Have any of your family had:

	Relation to Patient – maternal/paternal		Relation to Patient – maternal/paternal
☐ Heart Disease		☐ Asthma	
☐ Diabetes		☐ Mental Illness	
☐ Cancer		☐ Other	

SOCIAL HISTORY

Do you use any of the following:	(list amount where appropriate)
Tobacco	☐ No ☐ Yes How many cigarettes per day ..... or How many cigarettes per week ..... ☐ Ceased smoking Year .....
Alcohol	☐ No ☐ Yes How many standard drinks per day ..... or How many standard drinks per week .....
Drug use	☐ No ☐ Yes Type.....Frequency.....

MEASUREMENTS

Weight	kg	***Height***	cm

BLOOD PRESSURE

When was the last time your blood pressure was taken?

SUN PROTECTION

How often do you use the following to protect yourself from the sun when outdoors?

Protective clothing	☐ Always	☐ Often	☐ Not sure	☐ Never
Sunscreen creams	☐ Always	☐ Often	☐ Not sure	☐ Never

FOR THOSE 65 YEARS AND OLDER

When was the last time you were immunised?

Influenza	Date:	☐ Not sure	☐ Never
Pneumococcal pneumonia	Date:	☐ Not sure	☐ Never

FEMALES

When did you last have?

Pap smear	Date:	☐ Not sure	☐ Never
Breast Check	Date:	☐ Not sure	☐ Never

MALES

When did you last have an overall check up:	Date:	☐ Not sure	☐ Never

To enable ongoing care and total quality improvement within this practice, and in keeping with the Privacy Act 1988 and National Privacy Principles, we wish to provide you with sufficient information on how your personal health information may be used or disclosed and record your consent or restrictions to this consent.

Your personal health information will only be used for the purposes for which it is collected, or as otherwise permitted by law and we respect your right to determine how your personal health information is used or disclosed.

The information we collect may be collected by a number of different methods and examples may include: medical test results, notes from consultations, Medicare and health insurance details, data collected from observations and conversations with you, and details obtained from other health care providers (e.g. specialist correspondence).

By signing below, you (as a patient/guardian) are consenting, that on obtaining your personal health information it may be used or disclosed by the practice for the following purposes:

- Follow up reminder/recall notices for treatment and preventive healthcare.
- For accounting purposes and the collection of professional fees.
- The diagnosis and treatment of any health condition, including the communication of relevant information only, to practice staff, specialists and other healthcare providers to ensure quality care is provided.
- Accreditation and Quality Assurance activities are conducted by professionally trained non-treating GP's and other professionally trained and qualified persons e.g. General Practice Managers.
- For legal related disclosure as required by a court of law.
- For the purposes of research only where de identified information is used.
- To allow medical students and staff to participate in medical training/teaching using only de identified information.
- For disease notification as required by law.
- For use when seeking treatment by other doctors in this practice.

At all times, we are required to ensure your details are treated with the utmost confidentiality. Your records are very important and we will take all steps necessary to ensure they remain confidential.

I, _____ give my permission for my personal health information to be collected, used and disclosed as described above. I understand only my relevant personal health information will be provided to allow the above actions to be undertaken and I am free to withdraw, alter or restrict my consent at any time by notifying this practice in writing.

Patient Name: (Please Print) _____
Signature: _____ Date:_____

If not patient signing your name (Please Print)_____

Your relationship to patient (e.g. Mother, Father, guardian)_____

PRACTICE USE ONLY: Witnessed by:
(Staff Signature)_____

PLEASE TELL US HOW YOU HEARD ABOUT OUR PRACTICE:		
Newspaper	Word of mouth	Sign out front
Other		