Welcome To GP After Hours Mount Lawley

Please alert staff immediately if you are experiencing any of the following:
Difficulty Breathing - Chest Pain - Heart Palpitations - Allergic reaction

New GP After Hours Patient Information Form

Could you please assist us by completing the following –

Surname	(Mr / Mrs / Ms / Miss / Dr) *(circle appropriate title)*
First Name	(Male / Female / Intersex / Transgendered-Identify as:_____) *(circle as identified)*
Date of Birth	
Address	
Suburb	**Postcode:**
Phone	**Home**: **Mobile**:
Email Address (print) *(please circle)*	*I **do** | **do not** give permission for communication to be sent via email.*
Emergency Contact This is compulsory	**First Name:** **Surname:** **Relationship to you:** **Tel:**
How did you find out about us? *(please circle)*	**Website** **Facebook** **Regular GP Practice** **HealthEngine** **Family/Friend** **Drive by** **Pharmacy** **Other**_____

If you require any special consideration or assistance based on your cultural background please inform our staff when making your appointment.

☐ Yes – Please elaborate - _____

To assist with Medical Assessment and Care: Ethnicity *(your heritage)*_____

To assist with Health Initiatives – Do you identify as:

☐ Australian, non indigenous

☐ Aboriginal but not Torres Strait Islander

☐ Torres Strait Islander but not Aboriginal

☐ Both Aboriginal and Torres Strait Islander

☐ Prefer not to Answer

Country of Birth: _____

Languages (as well as English) spoken _____**Do you require a translator? Y / N**

Occupation _____

To help us with your ongoing care, please complete your Usual Medical Practitioner details below

Practice Name	
Doctor	
Address	
Contact Number **(if known)**	**Fax number:** **(If known)**
Please fax/send a copy of my notes to my Usual GP Practice **YES** ☐ **NO** ☐ *We will automatically fax/send a copy of your notes to your Usual GP Practice unless you tick NO*	
If you don't have a Usual Dr or Practice please tick here ☐	

Medicare Card Number

Reference Number
(number in front of your name)

Expiry Date

Please Turn Over

Health Information Collection and Use Consent Form

Please read this consent form carefully, and sign where indicated below

GP After Hours Mount Lawley is a private billing Practice.
WE DO NOT BULK BILL OR ISSUE ACCOUNTS.

- Payment is required at the end of the consult and we accept credit card, eftpos and cash. (No cheques, Diners or Amex)
- Medicare will rebate you a portion of the fee. We can lodge this here only if you have provided Medicare with your bank details.
- **PLEASE NOTE:** There may be extra costs additional to your consultation ie: Urine and Blood testing, Suturing etc. Pathology and radiology costs are not generated from or associated with our practice.
- **IMPORTANT: GP After Hours Mount Lawley DOES NOT PRESCRIBE SCHEDULE 8 DRUGS**
  Your personal information will only be used for the purposes for which it was collected or as otherwise permitted by law, and we respect your right to determine how your information is used or disclosed.

The information we collect may be collected by a number of different methods, and may include, but not limited to: medical test results, notes from consultations, Medicare 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/parent/guardian) are consenting to the collection of your personal information, and that it may be used or disclosed by the practice for the following purposes:

- Administrative purposes in the operation of our general practice.
- Billing purposes, including compliance with Medicare requirements.
- Follow-up reminder/recall notices for treatment and preventative healthcare, frequently issued by SMS.
- Disclosure to others involved in your health care, including treating doctors and specialists outside this medical practice. This may occur through referral to other doctors, or for medical tests and in the reports or results returned to us following the referrals.
- Accreditation and quality assurance activities to improve individual and community health care and practice management.
- 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.
- To comply with any legislative or regulatory requirements, e.g. notifiable diseases.
- 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.
Please complete the form below if you understand and agree to the following statements in relation to our use, collection, privacy and disclosure of your patient information.
I, _____ have read the information above and understand the reasons why my information must be collected, and the purposes for which my information may be used or disclosed. I understand that if my information is to be used for any purpose other than that set out above, my further consent will be obtained.

I, _____ give permission for my personal information to be collected, used and disclosed as described above, including contact via SMS to my mobile phone number, and/or Email address. I understand that only my relevant personal 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) _____

Failure to attend scheduled appointments will incur a Missed Appointment Fee. We require one hour notice for cancellations.

Please return this consent form and your Medicare Card to the Receptionist

GP After Hours Mount Lawley - Patient Medical Information

DATE: _____ NAME: _____ DATE OF BIRTH: _____

GENDER:

☐ Male
☐ Female
☐ Intersex
☐ Transgendered
Identify as_____

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

☐ No
☐ Yes – provide details:

CURRENT MEDICATIONS – Please list all your current medications, including complementary and over-the-counter medicines (e.g. homeopathic medicines such as vitamins and minerals etc.)

MEDICAL HISTORY - Do you have or have you had a history of the following?

☐ Surgery – provide details:
☐ Asthma
☐ Diabetes
☐ Hypertension
☐ Chronic Illness
☐ Other – provide details:

LIFESTYLE RISK FACTOR INFORMATION

Smoking

☐ No
☐ Ceased - date_____
☐ Yes - how many ___ day / ___ week

Alcohol

☐ No
☐ Yes - how many ___ day / ___ week / ___ month

Recreational Drug Use

☐ No
☐ Yes - type_____ frequency _____

FAMILY HEALTH HISTORY INFORMATION

Do any members of your family have:

☐ Heart Disease
☐ Asthma
☐ Diabetes
☐ Hypertension (high blood pressure)
☐ Mental Illness
☐ Cancer – type:
☐ Other significant - provide details:

MALES - Date of last check up_____

FEMALES - Date of last Cervical Smear_____
Date of last Mammogram_____