Patient Details Form

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Referred to see Specialist: Dr Greg Cunningham Dr Michael Kern Dr Andrew Miles Dr Paul Taylor Dr Yee Hein Dr Jason Tan Dr Vijaya Venkataraman Physiotherapist

Surname:

First names:

Height:

Weight:

Address:

Email:

Date of Birth:

Occupation:

Home Phone:

Mobile Phone:

Health Fund Name and Membership Number:

Medicare Number:

Ref:

Expiry:

Pension/DVA Card Number:

Ref:

Expiry:

Usual GP (Dr name & practice):

GP Practice Address:

Next of Kin:

Relationship:

Tel:

Where did you hear about us? Friend or family GP Allied Health Other Medical Specialist Online Advertising ie newspapers Other: ____________

Workers Compensation & Third Party Patients

Solicitors (if applicable): Name: Address:

Insurer: Name: Address:

Name of Case Manager:

Date of Injury:

Claim Number:

Employers' Details:

Case Manager's Tel:

Fax:

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Medical History Form

Please indicate if you have or had in the past the below medical conditions:	YES	NO
Heart Conditions (stents, palpitations, irregular beat, etc.)		
Heart Attacks (myocardial infarction)**/ Angina**		
Hypertension (high blood pressure)		
Diabetes (high blood sugar – tablet or injection controlled)		
Respiratory Illness (lung problems)		
Bleeding Disorders or **'Blood Thinning' Tablets** (eg warfarin, aspirin, clopidogrel)		
Hepatitis (liver virus or disease)		
HIV/AIDS		
Cancer		
Deep Vein Thrombosis (blood clots in the leg)		
Pulmonary Embolism (blood clots in the lung)		
Renal Disease (kidney disease)		
Problems with Anaesthetics		
Neurological Disease, Stroke or Mini Stroke (CVA/TIA)		
Memory Issues/Dementia		
Thyroid Problems		
Sleep Apnoea/Use of CPAP		
Digestive Problems/Constipation/Ulcers		
History of Anxiety or Depression		
Recent Viral Illness (flu-like illness)		

If you answer YES for any of the above, please provide more details including treatment.

What medications are you taking now? Include frequency and dosage if known.

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Are you allergic to any medications? **YES** **NO**

If YES, which ones?

Please list any operations you have had and their dates. Did you have any major complications?

Are you currently driving? **YES** **NO**

Please list the full name of Specialist Doctors you are currently attending:

Alcohol:	**Never**	**Stopped over a year ago**	**Yes**	Units per week
Smoking:	**Never**	**Stopped over a year ago**	**Yes**	Packs per week

Female History

Birth control pills **YES** **NO** Hormone replacement treatment (HRT) **YES** **NO**

Please indicate on a scale of 0 - 10 the general level of pain you have experienced over the last few days with 0 being No Pain and 10 being Pain as bad as it could possibly be.

Arm	Neck/Shoulder	Lower Back	Leg

Further comments on your level of pain (how long you have had it, how it started, what makes it better or worse)

Please note:

You will be given a Patient Symptom Chart to fill out at your consultation.

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Patient consent to collect and disclose information

On 21 December 2001, changes to the Privacy Act 1988 came into effect requiring medical practitioners to obtain consent from their patients to collect, use and disclose that patient's personal information.

Collection

This means we will collect information that is necessary to properly advise and treat you. Such necessary information may include:

- Full medical history
- Family medical history
- Ethnicity
- Contact details
- Medicare/private health fund details
- Genetic information
- Billing/ account details

The information will normally be collected directly from you. There may be occasions when we will need to obtain information from other sources, for example:

- Other medical practitioners, such as former GP's and specialists
- Other health care providers, such as physiotherapists, occupational therapists, psychologists, pharmacists, dentists, nurses; and
- Hospital and Day Surgery Units.

Both our practice staff and the medical practitioners may participate in the collection of this information.

In emergency situations we may need to collect personal information from relatives or other sources where we are unable to obtain your prior express consent.

Use & Disclosure

With your consent, the practice staff will use and disclose your information for purposes such as:

- Account keeping and billing purposes
- Referral to another medical practitioner or health care provider
- Sending of specimens, such as blood samples for analysis
- Referral to a hospital for treatment and/or advice
- Advice on treatment options
- The management of our practice
- Quality assurance, practice accreditation and complaint handling
- To meet our obligations of notification to our medical defence organisation or insurers
- To prevent or lessen a serious threat to an individual's life, health or safety; and
- Notification or diagnosis of certain communicable diseases
- Where legally required to do so, such as producing records to court, mandatory reporting of child abuse or the notification of diagnosis of certain communicable diseases

Access

You are entitled to access your own health records at any time convenient to both yourself and the practice. Access can be denied where:

- To provide access would create a serious threat to life or health
- There is a legal impediment to access
- The access would unreasonably impact on the privacy of another
- Your request is frivolous
- The information relates to anticipated or actual legal proceedings and you would not be entitled to access the information in those proceedings
- In the interests of the national security

We ask that, where possible, your request will be writing. We may impose a charge for photocopying or for staff time involved in processing your request. Where you dispute the accuracy of the information we have recorded you are entitled to correct that information. It is our practice policy that we will take all steps to record all of your corrections, and place them with your file but will not erase the original record.

Consent

I provide my consent for NeuroSpine Institute to collect, use and disclose my personal information as outlined above.

I understand that I am entitled to my own health records except where access would be denied as outlined above.

I understand that I may withdraw my consent as to use and disclosure of my personal information (except when legal obligations must be met).

I give permission for my de-identified clinical detail to be used for the purpose of audit, teaching and/or medical research.

I consent to my clinical and personal information being released to other practitioners, insurers, hospitals and fee payers involved in the management of my condition.

I understand I am responsible for the disclosure of all relevant health information to my treating practitioners so that they may choose treatment options appropriately and reduce the risk of me suffering adverse events.

Important

All details given on these information sheets will be kept in the strictest confidence in accordance with National Privacy Legislation.

Signature ______________________ Date ______________________

Submit completed form

1. Save this pdf (do not fill out in your web browser)
2. Open in Adobe Acrobat Reader (link to **download here**)
3. Fill out form
4. Save pdf **before** clicking "submit"
5. Click "submit" and attach pdf to the email (paperclip icon)
6. Hit send to **info@nsiwa.com.au**

SUBMIT