A/Prof Harsha Chandraratna
Dr Andrew Kiyingi
Dr Bill Gong

GENERAL & BARIATRIC SURGEONS

FRACS Fellow of the Royal Australasian College of Surgeons

PATIENT INFORMATION FORM

Title: ...... First Name: .... Surname: .... DOB: ....

Address: ....

Suburb: .... Post Code: .... *Email: ....

** Do you wish to receive correspondence via email? Yes / No*

Home Phone: .... Work Phone: .... *Mobile: ....

** Do you wish to receive an automated SMS reminder? Yes / No*

Medicare Number: .... Ref No:(*number next to name*) .... Expiry: ....

Private Health Fund: .... Membership No: ....

How long have you been with your fund? Months: .... Years: ....

DVA Card No: .... DVA Card Colour: ....

REFERRAL DETAILS

Name of Referring GP/Specialist/...

Address: ....

If your current GP is not referring you to this clinic, please include the name and address, so a copy of your report can be mailed directly to their practice:

GP / Practice Name: ....

Address: ....

Suburb: .... Post Code: .... Phone: ....

NEXT OF KIN

First Name: .... Surname: .... Relationship: ....

Home Phone: .... Work Phone: .... Mobile: ....

Fess are payable at the time of consultation by cash, cheque, EFTPOS, MasterCard or Visa. Some services attract charges that cannot be claimed from Medicare, however you will be advised of this in advance. The receptionist will try and advise you at the time you book your consultation of the likely charges. Subsequent visits attract a lower fee than the initial consultations.

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COLLECTION OF PERSONAL INFORMATION, PRIVACY ACT 1988

We require your consent to collect personal information about you. Please read this information carefully, and sign where indicate below.

This medical practice collects information from you for the primary purpose of providing quality health care. We require you t provide us with your personal details and a full medical history so that we may properly assess, diagnose and treat illnesses and b pro-active in your health care. We will also use the information you provide in the following ways:

- Administrative purposes in running our medical practice
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements
- 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 followin the referrals. If necessary, we will discuss this with you.
- Disclosure to other doctors in the practice, locums and by Registrars attached to the practice for the purpose of patient care and teaching. Please let us know if you do not want your records accessed for these purposes, and we will note your record accordingly.
- Disclosure for research and quality assurance activities to improve individual and community health care and practic management. You will be informed when such activities are being conducted and given the opportunity to "opt out" of an involvement

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I have read the information above and understand the reasons why my information must be collected. I am also aware that th practice has a privacy policy on handling patient information.

I understand that I am not obliged to provide any information requested of me, but that my failure to do so might compromise th quality of the health care and treatment given to me.

I am aware of my right to access the information collected about me, except in some circumstances where access might legitimatel be withheld. I understand I will be given an explanation in these circumstances. I understand that if I request access to informatio about me, the practice will be entitled to charge me fees to cover

- Time spent by administrative staff to provide access at the employee’s hourly rate of pay
- Time necessarily spent by a medical practitioner to provide access at the practitioner’s ordinary sessional rate and
- For photocopying and other disbursements at cost

I understand that if my information is to be used for any other purpose other than set out above, my further consent will be obtained.

I consent to the handling of my information by this practice for the purposes set out above, subject to any limitations on access c disclosure that I notify this practice of.

Signed: .... **Patient Full Name:** .... **Date:** ....

MEDICAL HISTORY

FULL NAME: ....

MARITAL STATUS : …………………………………… NUMBER OF CHILDREN: …………………….. OCCUPATION: ………………………………………………………..

CURRENT MEDICAL PROBLEMS (*EG: ASTHMA, DIABETES*):

CURRENT MEDICATIONS:

PAST MEDICAL PROBLEMS:

PAST SURGERY:

ALLERGIES TO MEDICATIONS/DRESSINGS:

HOW MUCH TOBACCO DO YOU SMOKE? _________________ HOW MUCH ALCOHOL DO YOU DRINK? _________________

MEDICAL CONTACTS

Who is your referring doctor? ……

Are there other health care professionals involved in your care?

Other GP's: ……

Physician: ……..

Other Specialists: ………

Psychologist / Physiotherapist / Chiropractor: …….

Is there anyone that we should NOT write to about your surgery ?

…….

BLOOD THINNERS

Do you take any BLOOD THINNERS or anything that will reduce your blood from clotting?

(Example: Warfarin, Apixaban, Clopidogrel, Aspirin, Rivaroxabin, Dabigatran Also: Garlic, Ginger, Ginko, Fish Oil, Chinese Medicine)

DVT / EMBOLISM RISK

Have you ever had a deep venous thrombosis (DVT), clot or embolism?

Has anyone in your family had a deep venous thrombosis (DVT), clot or embolism?

IMMUNOSUPPRESSANT MEDICATION

Do you take any medication that may suppress your immune system?

REFERRAL INFORMATION

How did you hear about us?

Did you visit our website?

Is there anything on our website that you particularly liked?

Is there anything you would like to have seen on our website?

Is there anything you didn't like on our website?

GENERAL INFORMATION

Do you regularly lift more than 20kgs?

Have you ever had?

Cancer, Abdominal or Pelvic Surgery , Heart Attack or Heart disease

Any issue with PAST Anesthesia? IF YES PLEASE DETAIL BELOW

Do you have a family history of? (Please circle)

Colon Cancer Ovarian cancer Breast Cancer Bleeding or Clotting (Thombosis)