PERSONAL DETAILS (PAGE 1)

Title: _____ **Date of Birth:** _____ / _____ / _____

Given Name(s): _____ **Surname:** _____

Preferred Name: _____

If the patient is younger than 15 years of age, please provide the details of the parent / guardian below:

Title: _____ **Date of Birth:** _____ / _____ / _____

Given Name: _____ **Surname:** _____

Medicare Card Number: ☐☐☐☐☐☐☐☐☐☐ ☐ **Ref No:** ☐ (to the LEFT of your name)

Street Address (or PO Box): _____

Suburb: _____ **State:** _____ **Postcode:** _____

Email: _____

Occupation: _____ **Hand orientation:** ☐ Right handed ☐ Left handed

Contact number(s):
Mobile: _____ Home: _____ Work: _____

☐ I do NOT wish to receive SMS reminders

Next of Kin Details (family member / friend / medical power of attorney, etc)

Name: _____ Relationship: _____

Contact number: _____

CLAIM DETAILS

Medicare Card Number: ☐☐☐☐☐☐☐☐☐☐ ☐ Expiry: _____ / _____

Reference Number: ☐ (number to the LEFT of your name)

Private Health Insurance (please list hospital cover only):

Fund Name: _____ Membership number: _____

Have you held hospital cover for 12 months or more? ☐ Yes ☐ No

Level of Hospital Cover (if applicable): ☐ Basic ☐ Bronze ☐ Silver ☐ Gold

DVA Cards

Dept. Veterans Affairs: _____ ☐ Gold ☐ White Expiry: ____ / ____ / ____

Is this visit related to a WorkCover or TAC injury? ☐ Yes ☐ No **Has the claim been accepted?** ☐ Yes ☐ No

Nature of injury: _____

WorkCover Details (if applicable)

Claim number: _____ Date of Injury: _____ / _____ / _____

Insurer: _____ Employer: _____

Case Manager: _____ Case manager email: _____

TAC Details (if applicable)

Claim number: _____ Date of Accident: _____ / _____ / _____

☐ *In the event that my claim becomes inactive, I will be responsible for any outstanding accounts*

REFERRER / GP DETAILS (PAGE 2)

Referring Practitioner Details

Name: _____ Clinic: _____

Suburb: _____

GP Details (if different than above)

Name: _____ Clinic: _____

Suburb: _____

Do you consent to correspondence being sent to referrer / GP / other health professionals involved in your care? ☐ **Yes** ☐ **No**

MEDICAL HISTORY

Are you a diabetic / on diabetic medication? ☐ Yes ☐ No

If yes, please provide details (i.e. type & medication): _____

Do you take any blood thinning agents (e.g. Warfarin, Plavix, Aspirin, Asasantin)? ☐ Yes ☐ No

If yes, please provide details: _____

Are you a smoker? ☐ Yes ☐ No

Do you have any allergies (e.g. latex, tapes)? ☐ Yes ☐ No

If yes, please provide details: _____

Please tick if you suffer / have a history of any of the following medical conditions:

☐ High blood pressure ☐ Heart disease ☐ Hepatitis C ☐ Bleeding tendency

☐ Blood clots ☐ Cardiac stent ☐ Stroke / TIA ☐ Chronic infection

☐ DVT / PE ☐ Epilepsy ☐ HIV

☐ Other: _____

Please list current medications: _____

_____

Photography: in some cases, photographic records are made and used for educational purposes or scientific publications. They are stored securely and kept anonymous. Do you consent to photos being taken? ☐ Yes ☐ No

SETTLEMENT OF ACCOUNT

All accounts must be settled on the day of your consultation.

A copy of the terms of contract for settlement of your account is displayed at the reception desk and is also available upon request.

SIGNATURE: _____ **DATE:** _____ / _____ / _____

The confidentiality of your personal details and medical history will be strictly maintained.
A hard copy of the privacy policy is available on request or available on our website: https://www.vhsa.com.au/privacy-policy-2/

Victorian Hand Surgery Associates

Mr Stephen Tham
Mr Peter Maloney
A/Prof David McCombe
Mr William Alexander
Mr James Thomas
Mr George Miller

An association of independent specialist surgeons

CONSENT FORM: HEALTH INFORMATION COLLECTION & USE

As a patient of our medical practice, we require you to provide us with your personal details and full medical history, so that we may properly assess, diagnose, treat and be proactive in your health care needs.

We aim to protect the privacy and secure storage of your health information. You can request a copy of our privacy policy which includes information about the collection, use, and disclosure of your health information.

We require your consent to collect personal information in the following ways:

- Administrative purposes in running the medical practice
- Billing purposes including compliance with Medicare and Health Insurance Commission requirements
- Disclosure to others involved in your care including treating doctors and specialists outside this medical practice. This may occur through referral to other doctors, for medical tests, or in the reports or results returned to us following referrals
- Disclosure to other doctors in the practice, locums, etc attached to the practice for the purpose of patient care and teaching
- For research and quality assurance activities to improve individual healthcare. Usually, information that does not identify you is used, but should information that will identify you be required, you will be informed and given the opportunity to opt out of any involvement
- To comply with any legislative or regulatory requirements (e.g. notifiable diseases)

You can decline to have your health information used in all or some of the ways outlined above, but it may influence our ability to manage your health care to provide the best outcome for you.

- I have read the information above and understand the reasons why my information must be collected. ☐
- I understand that I am not obliged to provide any information requested of me, but failure to do so may compromise the quality of health care and treatment given to me. ☐
- I am aware of my rights to access the information collected about me, except in some circumstances where access may be legitimately withheld. I will be given an explanation in these circumstances. ☐
- 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 the practice for the purpose set out above, subject to any limitations on access or disclosure of which I notify this practice. ☐

OR

I am unsure and would like to discuss this further with someone from the medical practice before I sign. ☐

PATIENT / GUARDIAN NAME: _____ **SIGNATURE:** _____ **DATE:** ____ / ____ / ____

CONSENT FORM: EMAIL FOR NON-SECURE EMAIL COMMUNICATION

This practice requires your written consent to send and receive emails to you and other health professionals about you.

- We cannot guarantee that the security and confidentiality of any email transmissions
- Because of the many factors beyond our control, we accept no liability for misdelivered, misaddressed, or intercepted emails
- We are not liable for breaches of confidentiality caused by yourself or a third party
- We have a strong firewall and current antiviral protection software. While unlikely, these systems are capable of being compromised
- Your personal details will only be used in emails with other health providers
- Your personal details will not be passed on without your consent

PATIENT NAME: _____ **DATE OF BIRTH:** _____ / _____ / _____

EMAIL ADDRESS: _____

- Please include your full name and date of birth in all emails you send to us
- Please advise us if you have recently changed your email address
- You are responsible for protecting your password or other means of access to your email account

PATIENT / GUARDIAN NAME: _____ **SIGNATURE:** _____ **DATE:** ____ / ____ / ____