WOMEN'S HEALTH CLINIC

Patient Information
+ Consent to Release Medical Information

TITLE: [MISS / MS / MRS / DR]

SURNAME: FIRST NAME:

HOME ADDRESS:

POSTAL ADDRESS:

MOBILE: LANDLINE:

EMAIL:

DATE OF BIRTH: __/__/____ OCCUPATION:

NEXT OF KIN NAME: NEXT OF KIN PHONE NO:

RELATIONSHIP TO NEXT OF KIN:

DO YOU IDENTIFY AS ABORIGINAL OR TORRES STRAIT ISLANDER?

ABORIGINAL ☐ TORRES STRAIT ISLANDER ☐ BOTH ☐ NO ☐

MEDICARE NO: REF # EXPIRY DATE __/_____

HEALTH FUND: HEALTH FUND NO:

REFERRING DOCTOR: CLINIC SUBURB:

GP: CLINIC SUBURB:

CONSENT TO RELEASE MEDICAL INFORMATION

- ✓ I give my consent to the Women's Health Clinic or their agents and advisors to contact medical practitioner or any other bodies I have consulted, to obtain health and other information that may be pertinent to my care.

- ✓ I authorise those medical practitioners or bodies to release such information, which may include sensitive health information, to the Women's Health Clinic or their agents and advisors, as may be required.

NAME: SIGNATURE:……

DATE: __/__/____

WOMEN'S HEALTH CLINIC

PATIENT HEALTH QUESTIONNAIRE

TITLE: [MISS / MS / MRS / DR / OTHER]

SURNAME: FIRST NAME:

DATE OF BIRTH: __/__/____ WEIGHT [kg]: HEIGHT [cm]:

GENDER AND PREFERRED PRONOUNS:

PAST MEDICAL HISTORY

_____

_____

_____

_____

_____

_____

DO YOU HAVE ANY SPECIFIC MEDICAL ISSUES?

Yes	No		Yes	No	
☐	☐	DIABETES	☐	☐	ASTHMA/COPD/OTHER LUNG PROBLEMS
☐	☐	HEART DISEASE	☐	☐	STROKE/S
☐	☐	HIGH BLOOD PRESSURE	☐	☐	OTHER:
☐	☐	BLOOD CLOTS	☐	☐	ALCOHOLIC DRINKS PER WEEK
☐	☐	ANY ANAESTHETIC COMPLICATIONS	☐	☐	HOW MUCH DO YOU SMOKE / DAY
☐	☐	ALLERGIES	☐	☐	HAVE YOU PREVIOUSLY SMOKED

LIST ALLERGIES

_____

WHEN DID YOU STOP

_____

MEDICATIONS

DO YOU TAKE BLOOD THINNING MEDICATION Yes ☐ No ☐ *LIST MEDICATIONS*

MEDICATION LIST	DOSE	AM/PM
_____	_____	
_____	_____	
_____	_____	

WOMEN'S HEALTH CLINIC

Patient Information
+ Consent to Release Medical Information

Patient privacy is a vital priority of our practice as we aim to provide high quality medical services. The *National Privacy Act* sets out requirement for handling of information, which we are bound by.

Doctors and staff collect information [personal, sensitive and health] about you for the purpose of providing the best health care. In order to do this, we require you to provide us with your personal details and a full medical history, so we may properly assess, diagnose, treat and be proactive with your health needs. We have a legal and ethical duty to protect your patient information.

In summary, your information will be used in the following ways:-

- Administrative purposes in running our medical practice.
- Billing purposes including compliance with Medicare and Health Insurance Commission requirements health fund claims and debt collection.
- Disclosure, where required, to various medical and professional bodies including medical defence organisations.
- In referral to others involved in your health care, both within and outside of our practice, for further treatment or tests and investigations, so that quality health care is not compromised. This may include, but is not limited to, doctors, nurses, therapists, medical technicians, hospitals, day theatres and others.

When sharing your information with others, only as much of your information will be disclosed, as is necessary for the purpose.

PATIENT AGREEMENT

- ✓ I have read the above information and understand the reasons why my information must be collected, recorded and shared
- ✓ I understand I am not obliged to provide any information requested of me, but in not doing so, I might compromise the quality of the health care treatment I receive
- ✓ I am aware of my rights to access the information collected about me and recorded, except in rare circumstances where access might be legitimately withheld. I understand that I will be given an explanation in these circumstances.
- ✓ I understand that my consent will be obtained if my information is to be used for any other purposes not described above.
- ✓ I agree that information about me obtained and recorded by this practice, may be used and shared in accordance with the summary above, except for any limitations on access or disclosure that I notify the practice in writing.
- ✓ I allow the take of clinical photos and video, where required, and agree that this content will form part of my medical record.
- ✓ I agree not to film/photograph/record the Women's Health Clinic, or their agents and advisors, without their written consent.
- ✓ I agree to contact the clinic within two (2) weeks of my appointment to receive test results.

CANCELLATION POLICY

We strive to give excellent medical care and, to help us achieve this, we kindly request that you give us at least 24 hours notice if you need to cancel or change your appointment. This will allow other patients to be scheduled into you appointment time.

NAME: SIGNATURE:.....

DATE: __/__/____