DR RODNEY ALLAN
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NEUROSURGEON · ENDOVASCULAR NEUROSURGEON

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Patient information form

☐ Mr ☐ Mrs ☐ Ms ☐ Miss Other

First name Middle name

Surname

Date of birth / /

Address

Suburb State Postcode

Home phone

Work phone

Mobile

Email

Next of kin

Relationship Contact number

Medicare No. Ref No.

Valid to /

Private health fund Membership No.

Level of cover Covered for surgery in a private hospital? ☐ Yes ☐ No ☐ Not sure

Pension No. Valid to /

Type *(aged, disability)*

DVA No.

DVA card ☐ Gold ☐ White ☐ Other *(please specify):*

Referrer details

Referring doctor

Practice address

Phone

Your usual GP

Practice address

Phone

Are there any other medical practitioners you would like to have copied on your correspondence apart from your referring doctor and usual GP?
Please list their names and addresses below.

Workers Compensation / CTP / insurance claim details

Please fill out the following information if you have a Workers Compensation, CTP or other Third Party insurance claim.

Insurance company

Claim number

Case manager

Phone

Approval received

Please note that if you have not organised pre-approval from your insurance company you will be charged the Workers Compensation rate for your visit. You will then need to claim the fee back from your insurance company.

Please confirm that you understand these terms:

Patient name

Signed

Date ☐☐/☐☐/☐☐☐☐

Clinical information form – Confidential

Patient name

Reason for referral

Occupation

Do you have any of the following? *(Please tick all that apply)*

- ☐ Diabetes Type 1 or 2
- ☐ Asthma
- ☐ Hepatitis
- ☐ Stroke
- ☐ HIV/AIDS
- ☐ Arthritis
- ☐ Epilepsy
- ☐ Seizures
- ☐ Indigestion
- ☐ Psychological issues
- ☐ High blood pressure
- ☐ Heart problems
- ☐ Fainting
- ☐ Dizzy Spells
- ☐ Bruise/bleed easily
- ☐ Thryoid problems
- ☐ Kidney problems
- ☐ Anaemia
- ☐ Palpitations
- ☐ Tuberculosis
- ☐ Glaucoma
- ☐ Reflux
- ☐ Ulcer
- ☐ Pregnancy ☐ months
- ☐ Weight loss/gain
- ☐ Chest pain
- ☐ Change in appetite
- ☐ Altered taste or smell
- ☐ Fatigue
- ☐ Low blood pressure
- ☐ Vertigo
- ☐ Sinus problems
- ☐ Ringing in ears
- ☐ Hearing loss
- ☐ Blurred vision
- ☐ Double vision
- ☐ Shortness of breath
- ☐ Trouble breathing
- ☐ Vomiting
- ☐ Incontinence
- ☐ Headache
- ☐ Memory loss
- ☐ Loss of consciousness
- ☐ Weakness
- ☐ Falling down
- ☐ Vertigo
- ☐ Concussion
- ☐ Back pain
- ☐ Neck pain
- ☐ Numbness
- ☐ Hypertension
- ☐ Pacemaker
- ☐ Elevated cholesterol
- ☐ Fibromyalgia
- ☐ Long standing infections
- ☐ Liver disease
- ☐ Gastric ulcers
- ☐ Pulmonary embolism

Do you smoke? ☐ No ☐ Yes. How much?

Are you an ex-smoker? ☐ No ☐ Yes

Do you drink alcohol? ☐ No ☐ Yes. How much? _____

Are you taking Aspirin? ☐ No ☐ Yes.

Are you taking Warfarin? ☐ No ☐ Yes.

Any other blood thinners? ☐ No ☐ Yes. Their names? _____

Are you taking Clopidogrel / Plavix / Iscover? ☐ No ☐ Yes.

Family member history of similar illness? ☐ No ☐ Yes.

Right or left handed? ☐ Right ☐ Left

Height _____ Weight _____

Previous Illnesses	Year	Previous Operations	Year

Medications	Dose	Times per day

Do you have any allergies? ☐ No ☐ Yes. What are they? _____

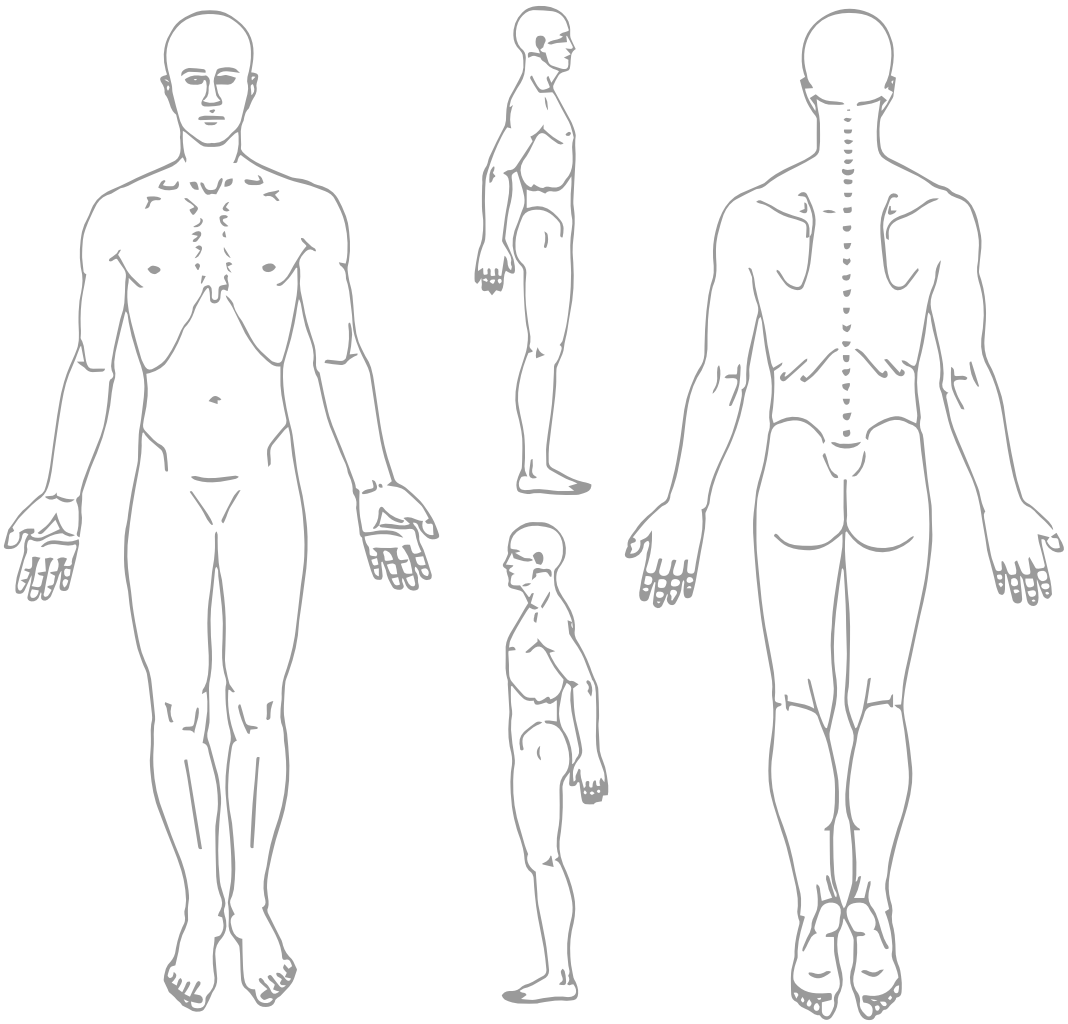
Drug and reaction _____

Please complete this page once you have printed the form.

Pain drawing

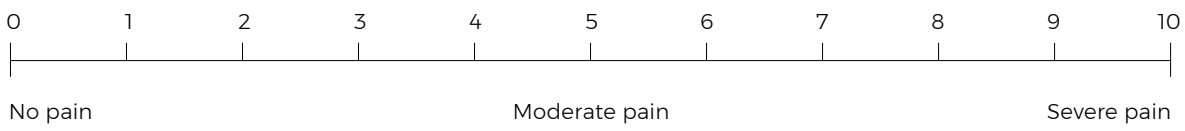
Please mark your symptoms on these drawings using the symbols:

Stabbing pain:	//////////////	Numbness:	= = = =
Burning pain:	XXXXXX	Pins & needles:	+++++++
Ache:	OOOOOO		



Pain scale

Please mark the severity of your current pain with an 'X' on the pain scale below:



Privacy consent and information

The Privacy Act 1988 requires medical practitioners to obtain consent from their patients to collect, use and disclose a patient's personal information. Our privacy policy is available on request to all patients.

Collection

We will collect information that is necessary to advise and treat you that may include:

- Medical history
- Family medical history, genetic information, ethnicity
- Contact details
- Billing details/ Medicare number/ health fund details

Details will be stored in your notes and on our computer system. Information will be collected from you and other sources such as your GP, specialist, other health care providers such as physiotherapists, nurses, and hospitals. Both our practice staff and medical practitioners will participate in collection of this information. In an emergency situation we need to collect information from other sources where we are unable to obtain your prior consent.

Health privacy principles apply to all photographic images and audio-visual records. We provide for the secure storage, access to, use and disclosure of these records.

The storage or transfer of personal health information on portable media such as USB, CD, laptop, iPad or Tablet is limited to employer-owned media, and used on a temporary needs basis only. Reasonable steps are taken when storing or transferring information in this way to reduce the risk of unauthorised access to the information, such as developing password entry into documents or systems.

Use and disclosure

With your consent the practice staff use and disclose your information for purposes including;

- Informing your GP and referring specialists on your treatment
- Referral to other doctors, health professionals, ordering tests and hospital admission
- Quality assurance, practice accreditation and complaint handling
- Account keeping and billing e.g Medicare, health funds, insurance companies
- Practice management
- 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
- Where legally required to do so such as producing personal information that could identify a person will be removed
- Research. Where information is to be disclosed to another party "de-identification" of information will be used – that is, personal information that could identify a person will be removed
- Patient data will be used for the purposes of HREC-approved research projects.

Access

You are entitled to access your own health records. If access is requested we ask that your request be in writing. Where you dispute the accuracy of the information you are entitled to correct that information. We will take all steps to record any of your corrections and place them with your file but will not erase the original record. Access can be denied in some specific cases.

Consent

I provide consent for Dr Rodney Allan to collect, use and disclose my personal information 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.

Patient name

Signed

Date

☐☐/☐☐/☐☐☐☐