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| **ATTENDING PATIENT(S) DETAILS****PLEASE ONLY FILL IN THE DETAILS OF THE PATIENT(S) BEING SEEN – NOT OTHER ATTENDING FAMILY MEMBERS** |
| **TITLE** | **FIRST NAME(S) AS ON MEDICARE CARD** | **LAST NAME** | **DATE OF BIRTH** | **MEDICARE CARD REFERENCE #****(number next to patient’s name)** | **TICK IF PRIMARY CONTACT** |
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| **MEDICARE CARD NUMBER: \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ EXPIRY DATE: \_\_\_\_\_ /\_\_\_\_\_** |
| **FOR MINORS ONLY – PLEASE NOMINATE ONE PARENT/GUARDIAN TO BE THE ACCOUNT HOLDER FOR MEDICARE ONLINE CLAIMING (WHEN THE PATIENT IS UNDER 18 YEARS OF AGE).****TITLE: NAME IN FULL: D.O.B\_\_\_\_\_ /\_\_\_\_\_ /\_\_\_\_\_\_ REFERENCE #\_\_\_\_\_\_****RELATIONSHIP TO PATIENT:****MEDICARE NUMBER (if different to above): \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ EXPIRY DATE: \_\_\_\_\_ /\_\_\_\_\_ REFERENCE #­­\_\_\_\_\_\_**  |
| **PRIMARY CONTACT DETAILS****MOBILE: HOME NUMBER: EMAIL:** **FULL RESIDENTIAL ADDRESS (MANDATORY FIELD FOR MEDICARE ONLINE CLAIMING)** **STREET: STATE:****SUBURB: POST CODE:** |
| **GOVERNMENT HEALTH CARE CARD/PENSION CARD/SENIORS CARD – CENTRELINK – PLEASE SHOW RECEPTION** |
| **PENSION CARD H/CARE CARD COMMONWEALTH SENIORS CARD**

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| **NAME** | **PATIENT CUSTOMER REF NUMBER (CRN)** | **EXPIRY DATE** |
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**ADMINISTRATION ONLY:** **CENTRELINK CARD(S) SHOWN TO RECEPTION ☐ INITIALS:**  |
| **DEPARTMENT OF VETERANS AFFAIRS (DVA) - GOLD CARD ONLY - Please show reception****CARD NUMBER:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**ADMINISTRATION ONLY: DVA CARD SHOWN TO RECEPTION ☐ INITIALS:**  **PLEASE TURN OVER 🡪** |

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| **FOR ADULT PATIENTS ONLY – PLEASE NOMINATE AN EMERGENCY CONTACT BELOW****NAME: RELATIONSHIP TO PATIENT:****PHONE NUMBER: EMAIL:** |
| **FOR MINORS ONLY – PLEASE NOMINATE ALL AUTHORISED PARENTS/GUARDIANS**  Please list the names of parents /guardians who are the primary care givers to the child**IF BELOW IS LEFT BLANK, DETAILS WILL ONLY BE GIVEN TO THE ADULT WHO SIGNS THIS FORM.**

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| **FULL NAME** | **RELATIONSHIP TO PATIENT** | **CONTACT NUMBER** | **EMAIL ADDRESS** |
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| **CONSENT – TO BE SIGNED BY PATIENT / PARENT / GUARDIAN WHO IS 18 YEARS OR OLDER****I UNDERSTAND AND CONSENT THAT (please read carefully)*****I consent to the consultation letter being uploaded to MyHR*  YES NO** ***Your doctor may recommend an examination at the time of consultation and a chaperone is available if preferred.*****PLEASE INDICATE CONSENT BELOW:** ***I consent to an examination as recommended by the doctor*  YES NO** ***I require and consent to a chaperone being present*  YES NO** - Investigations may include skin testing, which rarely cause severe reaction (1:30 000), and for which the practice is prepared.- The consultation letter will ONLY be sent to the referring doctor; usually within 2 weeks’ time. - Additional copies to be sent to other providers involved in my care need to be requested at the time of consult. - Follow up queries following my consultation need to be directed to the referring practitioner or my usual GP.- Certificates of attendance letters for school or work need to be requested at the time of consultation.- Consult fees are to be paid in full following my consultation and are not eligible for a Medicare rebate without a referral.- Centrelink card (HCC/Pension) rates only apply if a **valid** Centrelink card is shown to reception on the day.I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_consent to the disclosure to other medical providers involved in my healthcare should they need information about my medical history, to the extent necessary and relevant to access/treat the condition that I have consulted the specialist practitioner about.**SIGNED**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DATE:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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