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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**   |  |  |  | | --- | --- | --- | | **NAME** | **PATIENT CUSTOMER REF NUMBER (CRN)** | **EXPIRY DATE** | |  |  |  | |  |  |  | |  |  |  |   **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.**   |  |  |  |  | | --- | --- | --- | --- | | **FULL NAME** | **RELATIONSHIP TO PATIENT** | **CONTACT NUMBER** | **EMAIL ADDRESS** | |  |  |  |  | |  |  |  |  | |  |  |  |  | |
| **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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