CAULFIELD ENDOSCOPY

Glen Eira Day Surgery

Initial Consultation Form

Patient Details

Your personal information is used for the following:

1. Assistance with diagnosis, treatment and accurate identification and communication;
2. Disclosure of information to other health professionals involved in your care; ie (general practitioner, specialists and allied health professionals)
3. Accounting and administration to comply with health fund and health insurance commission requirements;
4. Quality assurance within Caulfield Endoscopy

MR / MRS / MS / MISS / MST / DR **(Please Circle)** DATE OF BIRTH ______/______/______

FIRST NAME ______________________________

SURNAME ______________________________

ADDRESS ______________________________

______________________________ POSTCODE ______________

TELEPHONE (H)______________ (W)______________ (M) ______________

EMAIL ADDRESS ______________________________

MEDICARE NUMBER______________ REF #________ EXPIRY DATE ______/______/______

VETERAN AFFAIRS NUMBER______________ EXPIRY DATE ______/______/______

PENSION CARD NUMBER______________ EXPIRY DATE ______/______/______

PRIVATE HEALTH FUND______________________________

MEMBERSHIP NUMBER______________________________

FAMILY DOCTOR______________________________

ADDRESS______________________________ POSTCODE______________

HAVE YOU EVER BEEN ADMITTED TO CABRINI MEDICAL CENTRE? YES NO

CONSENT

I have read the above information and I give my consent to the use of my personal information in the above circumstance. I recognize that I have the right to withhold any information which may compromise my care. I consent that my personal details may be used to retrieve medical information, reports and results from medical facilities (hospitals, pathology providers and radiology providers).

ALL FEES ARE DUE AND PAYABLE AT TIME OF CONSULTATION

______________________________ ______/______/______

Signature of Patient / Authorised Person **Date**