



Patient Details – Please print clearly. Name to be written in accordance with Medicare details

Title First Name Surname

Address Suburb Postcode

Date of Birth Email

Home Phone Work Phone # Mobile #

Medicare # Exp IRN

Private Health Member Number #

Dept. Veteran Affairs # White Gold

General Practitioner

Medical Centre

Interested Parties

Next of Kin Phone #

Medical History Questions

	Y	N		Y	N
Do you have Hypertension? (High blood pressure)	<input type="checkbox"/>	<input type="checkbox"/>	Do you have Abnormal Cholesterol (Triglycerides)	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a bleeding problem / disorder?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have Diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have kidney problems?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have Peripheral Artery Disease? (Legs/Carotids)	<input type="checkbox"/>	<input type="checkbox"/>

Does your family have any history of Heart conditions? If yes, please provide details

Has anyone in your family had an Angioplasty (Heart artery stent)? If yes, please provide details

Do you have a Biventricular Pacemaker? If yes, please provide details on the Brand and Year of installation

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Do you have an ICD (Implantable Cardiac Defibrillator)? If yes, please provide details on the Brand and Year of installation

Do you have a Loop Recorder? If yes, please provide details on the Brand and Year of installation

Are you currently taking any medications? If yes, please list all the medication you re taking, including all prescription & non-prescription medications

Patient Consent to Collect and Disclose Information

The Privacy Act of 1988 requires all health practitioners to obtain consent from their patients to collect, use and disclose patients' information.

Collection

Access Cardiology staff will collect information that is necessary for your treatment such necessary information may include:

- Full medical and psychological history.
- Family medical and psychological history.
- Ethnicity.
- Medicare / Private health fund details.
- Billing and accounting information.
- Contact Details.

The information will normally be collected directly from you; however, there may be occasions when it will be necessary to collect information from other sources with your prior consent. These sources may include but are not limited to:

- Parents about children.
- Children about their family.
- Schools and teachers.
- Other health care providers.

In emergency situations we may have to collect information from relatives or other sources without your prior consent.

Use and Disclosure

With your consent we will use and disclose your information for purposes such as:

- Account keeping and billing.
- To reply to your referring doctor.
- Referral to another health care provide or hospital.
- Management of access cardiology including quality assurance, practice accreditations and complaint handing.
- To prevent or lessen a serious threat to an individual's life, health or safety.
- Where legally required to do so e.g. by a court, mandatory reporting etc.
- To meet our obligations of notification to medical defense organisations or insurer.

Access

You are entitled to have access to your own health records at any time convenient to all parties. Depending on the nature of the access requested a charge might be payable where the practice incurs costs in providing access. There are some circumstances in which access may be denied, but in such an event you will be advised of the reason. If you find any information we hold on you is inaccurate or incomplete, please advise us so that we can adjust your record. We are not able to erase the original record.

Sign

Date