THE FAMILY GP CLINIC | THE DIABETIC GP CLINIC

NEW PATIENT REGISTRATION & CONSENT current as of Aug 23

Welcome to The Family & The Diabetic GP Clinic. This New Patient Registration and Consent form is required to provide the best quality care. This form complies with the *RACGP Standards for General Practices*. This means your personal health information is kept private and secure, as required by federal and state privacy laws.

Please complete all sections and read the Personal & Health Information Consent section at the end of this form.

If you have any concerns, please leave blank and discuss with your GP .

PART A: **PERSONAL DETAILS**:-

Title:	**Surname**:	**First Name:**	**Middle Initial:**
Preferred Name:	**Date of Birth**: / /		
Gender:	☐ **Male** ☐ **Female** ☐ **Other**		
Marital Status:	☐ **Single** ☐ **Married** ☐ **De Facto** ☐ **Separated** ☐ **Divorced** ☐ **Widowed**		
Street Address:			
Postal Address: **(If different to street address)**			
Mobile Phone:	**Work Phone:**	**Home Phone:**	
Email:	**Occupation**:		
Do you have an advance health directive for end of life care?	☐ **Yes** ☐ **No** For more information talk to your GP.		
Organ Donation -	☐ **Yes** ☐ **No** For more information talk to your GP.		
Emergency Contact: (Name, Address & Phone No.) **Relationship to Patient:**			
Next of Kin: (Name, Address & Phone No.) **Relationship to Patient:**			
Medicare Card Number:	**Ref No:**	**Expiry:**	
DVA Number:	**Card Type:**	**Expiry:**	
Concession Card Number:	**Card Type:**	**Expiry:**	
Private Health Insurer:	**Number:**	**Expiry:**	

PART B: **CULTURAL BACKGROUND**:- Knowing your cultural background can help us provide healthcare that meets your individual needs.

To assist with health initiatives – are you Aboriginal or Torres Strait Islander?	☐ **No** ☐ **Aboriginal** ☐ **Torres Strait Islander** ☐ **Aboriginal & Torres Strait Islander**	
Other Cultural background: (e.g. Mediterranean, Asian)		**Country of Birth:**
Is English your first language:	☐ **Yes** ☐ **No** **Specify language:**	
If not, do you require an interpreter:	☐ **Yes** ☐ **No**	

How did you hear about us? Please tick the following:

Newspaper ☐ Facebook ☐ Word of Mouth ☐ Signage ☐ Google ☐ TV ☐

PART C: **ALLERGIES & MEDICINES**:-

Allergies and intolerances to medications:-	☐ **Yes** ☐ **No** **Nature:**
Regular Medications:-	

PART D: **YOUR HEALTH HISTORY**: -

Medical Conditions:	**Details: …… Date:……..**
Immunisations:	**No – I am Not Immunised** ☐ **Yes – I am Immunised:** ☐ **Immunisations up to date:(please circle) Yes No Unsure**
Operations:	**Details: …… Date:……..**
Family Medical History:	**Details: …… Date:……..**
Alcohol:	☐ I do not drink alcohol ☐ I do drink alcohol ……drinks/week
Smoker:	☐ Yes ☐ No ☐ Ex-Smoker

PART E: REMINDERS, REVIEWS, FOLLOW UP & AFTERCARE

We may contact you for the following:

1. **Appointment Reminders**
2. **Clinical Reminders** (eg. Things that are due, such as Cervical Screening Test, Immunisation, Diabetes Review, Care Plans, Blood Pressure Check)
3. **Clinical Communication** (eg. Short message that your Dr has requested to see you to advise the outcome of test results)
4. **Health Awareness** (eg. Important practice information to patients, such as availability of flu vaccines, changes to services, new doctors, fee changes)

I have read the above and hereby consent to the following communication types: (please tick)

□ **Appointment Reminders** □ **Clinical Reminders**
□ **Clinical Communications** □ **Health Awareness**

My preferred method of contact would be: (please tick all that apply)

□ **SMS to this mobile number ……** □ **Phone (landline and/or mobile)……**
□ **Email** □ **Letter**

- I confirm that I will notify the practice of any changes to my contact details.
- I acknowledge that I have a responsibility to contact the practice for results of tests ordered by my health provider.
- If my mobile number, as listed by the practice is utilised for more than one patient, I understand that all SMS and voicemail communications as consented to above will be sent to that number.

CHILDREN & OTHER FAMILY MEMBERS: (please leave blank if not applicable)

Other family members aged under 18 who consent to receive communication to the same contact number:

Name: _____ Date of birth: ____/____/____

Name: _____ Date of birth: ____/____/____

Name: _____ Date of birth: ____/____/____

Name: _____ Date of birth: ____/____/____

_____

PART F: MY HEALTH RECORD and ELECTRONIC TRANSFER OF PRESCRIPTION

Do you give consent to the handling of personal information of your My Health Record & Electronic Transfer of Prescriptions ?

☐ Yes ☐ No

PART G: TRANSFER OF HEALTH INFORMATION

You may have consistently consulted with a GP at another practice. The health information held by that GP may assist us with your future healthcare needs. You may wish to have a copy or a summary of your health records transferred to this practice. Please ask our receptionist for information about how this can take place.

PART H: CANCELLATION & FAILURE TO ATTEND POLICY

Please be aware that we do have a **Cancellation & Failure to Attend Policy**, which may result in a **$40 non-refundable fee**. This policy can be found at reception. Please contact the clinic with 24 hours' notice if you need to reschedule your appointment.

PART I: PATIENT SIGNATURE

Patient Name: _____ Patient Signature: _____

Date: _____/_____/_____ (Please note if signed as parent/guardian)

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PERSONAL & HEALTH INFORMATION CONSENT

We respect your rights to privacy and take our privacy obligations seriously. Our Privacy Policy can be obtained from:

- Our website www.diabeticgp.com.au - Our Reception Staff - By calling us on (07) 4724 0700

To enable ongoing care and total quality improvement within this practice and in keeping with the Privacy Act (1988) and the Australian Privacy Principles , we wish to provide you with sufficient information on how your personal health information may be used or disclosed and record your consent or restrictions to this consent.

Your personal health information will only be used for the purposes for which it was collected, or as otherwise permitted by law and we respect your right to determine how your personal health information is used or disclosed. The information we collect may be collected by a number of different methods and examples may include: medical test results, notes from consultations, Medicare and health insurance details, data collected from observations and conversations with you, and details obtained from other health care providers (e.g. specialist correspondence).

By signing below, you (as a patient/guardian) are consenting, that on obtaining your personal health information it may be used or disclosed by the practice for the following purposes:

- follow up reminder/recall notices (by SMS, phone call, emails or letter as noted above) for treatment and preventive healthcare;
- for accounting procedures and the collection of professional fees;
- the diagnosis and treatment of any health condition, including the communication of relevant information only, to practice staff, specialists and other healthcare providers to ensure quality care is provided;
- Accreditation and Quality Assurance activities are conducted by professionally trained non-treating GPs and other professionally trained and qualified persons, e.g. General Practice Managers;
- For legal related disclosures as required by Court of Law;
- For the purposes of research where de-identified information is used;
- To allow medical students and staff to participate in medical training/teaching using only de-identified information;
- For disease notification as required by law;
- For use when seeking treatment by other doctors in this practice.

At all times, we are required to ensure your details are treated with the utmost confidentiality. Your records are very important and we will take all steps necessary to ensure they remain confidential.

I, _____, confirm that the information I have given on this form is correct. I have read the information above and understand why my information is collected and how it is used. I give my permission for my personal health information to be collected, used and disclosed above. I understand only my relevant personal health information will be provided to allow the above actions to be undertaken. I consent to sharing of all relevant information between the general practitioners, nurses, allied health providers and non-clinical staff for the purpose of managing my health. I understand this information will be used to fulfil their duties in the course of planning and managing my health care.

I acknowledge that I am not obliged to provide any information requested of me, but that failure to do so might compromise the quality of care provided to me. I understand that I am free to withdraw, alter to restrict my consent at any time by notifying this practice in writing.

Patient (please print): _____

Signature: _____ Date: _____

If not the Patient signing – Your name (please print): _____