SIPPYDOWNS FAMILYCLINIC

Where your health comes first!

reception@sippydownsfamilyclinic.com.au
www.sippydownsfamiluclinic.com.au
Phone (07) 5391 3444 | Fax (07) 5391 3299
8 Fairfax St, Sippy Downs QLD 4556

Title ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Master ☐ Dr

Last Name: .... **Given Names**: .... **Middle Name**..........................

Date of Birth: .... **Gender**: ....

Marital Status: ....

The following information will assist us in the planning and provision of the best possible care:

Are you of Aboriginal or Torres Strait Islander origin?

☐ No ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander ☐ Both, Aboriginal and Torres Strait Islander

Country of Birth......................Ethnicity.............................. Is English your first language? ☐ Yes ☐ No

If English is not your first language, do you require an interpreter? ☐ Yes ☐ No

Are you registered for Closing the Gap (CTG)? ☐ Yes ☐ No

Street Address: ....

Suburb: .... Postcode: ....

Home Phone No: .... Work Phone No: ....

Mobile No: .... Email: .... @ ....

Do you have Private Health Insurance: ☐ Yes ☐ No

How would you like us to contact you? ☐ Home Phone ☐ Work Phone ☐ Mobile ☐ Email ☐ Post

We will only contact you by email if you fail to respond to two phone calls for follow up of non urgent results. Any other email contact for information is at the request of the patient and the patient or parent/carer/guardian accepts full responsibility for any misuse or breach of data which may occur.

Can we SMS or leave a message on your message-bank regarding an appointment? ☐ Yes ☐ No

Are we able to discuss your medical information with another member of your family or friend? ☐ Yes ☐ No

If *yes* – please state their name and relationship to you: ....

Can we put your name on a formal reminder system for preventive care? ☐ Yes ☐ No

PLEASE SIGN HERE IF YOU CONSENT TO THE ABOVE:..

Occupation: ....

Medicare Card No: ☐☐☐☐☐☐☐☐☐☐ Ref: ☐ Expiry Date: ....

☐ Health Care Card **or** ☐ Pension Card No: .... Expiry Date: ....

☐ DVA Card No: .... Expiry Date: .... ☐ Gold ☐ White

Next-of-Kin: .... Relationship:............................Ph No: ....

Emergency Contact: .... Relationship:............................Ph No: ....

If your child is subject to a Family Court Order which allows information to be shared with another person please provide the following: Name.......................................Mobile:...........................Relationship:..............

SIPPYDOWNS FAMILYCLINIC
Where your health comes first!

reception@sippydownsfamilyclinic.com.au
www.sippydownsfamiluclinic.com.au
Phone (07) 5391 3444 | Fax (07) 5391 3299
8 Fairfax St, Sippy Downs QLD 4556

How did you hear about this practice? (OK to tick more than one box)

☐ Radio ☐ Facebook ☐ Magazine Ad ☐ Google ☐ Other health provider

☐ Family/Friend ☐ Local ☐ Pharmacy ☐ Walked past ☐ Instagram

SIPPY DOWNS FAMILY CLINIC - USE OF PERSONAL INFORMATION CONSENT FORM

Amendments to the *Privacy Act 1988*has brought the introduction of the Australian Privacy Principles (APPs) These amendments redefine how healthcare services can manage your information.

1. WHAT INFORMATION DO WE COLLECT ABOUT YOU?

Sippy Downs Family Clinic doctors and staff collect information from patients primarily to provide the best quality and continuity of care. This may include other medical specialists, nurses, pathologists, healthcare providers and health administration services so that your health care is not compromised. We require you to provide us with your personal details and full medical history so that we may properly assess, diagnose, treat and be proactive in your health care. This includes your name, contact details, Medicare and health fund details. All personal information in relation to your visit is kept safely and securely within the Centre.

2. WHY AND HOW DO WE COLLECT THIS DATA?

We are required to obtain your consent to collect personal information about you. The information we collect about you helps us to keep up-to-date details about your needs, so we can care for you in the best possible way. We also use the information to better manage and plan this service. We will collect this information directly through you and will use the information you provide in the following ways:

- Administrative purposes in running our medical practice;
- Billing Purposes;
- Disclosure to others involved in your healthcare, including treating doctors and specialists outside the medical practice/day surgery. This may occur through referral to other doctors, or for medical tests and in reports or results returned to us through the referrals;
- Disclosure for research and quality assurance activities to improve individual and community health care and practice management; and,
- Emergency situations whereby medical officers/hospitals require access to patient notes for treatment purposes.

3. HOW CAN MY PERSONAL INFORMATION BE ACCESSED?

If you have changes to your personal information or wish to review your personal information, please ask one of our friendly staff or speak directly with the Practice Manager.

Please Note:

This consent form is written in accordance with Sippy Downs Family Clinic Privacy Policy (March 2014). If you wish to read this document in full prior to signing, we can provide you with a hard copy. Please ask a receptionist for more information.

PATIENT PRIVACY CONSENT

I have read the information above and understand the reasons why my information must be collected. I am aware that Sippy Downs Family Clinic has a privacy policy on handling patient information. I understand that I am not obliged to provide any information requested of me, but that my failure to do so might compromise the quality of the health care and treatment given to me. I am aware of my right to access the information by this practice for the purposes set out above, subject to any limitations on access or disclosure that I notify this practice of.

Patient Name: ____ **Date of Birth:** ______________________

Signature: ____ **Date:** ______________________________

Patient Signature/Guardian/Responsible Person/Statutory Health Attorney

An authorised person/power of attorney to be contacted in emergency circumstances:

Name: ____ **Phone No:** ______________________________

reception@sippydownsfamilyclinic.com.au
www.sippydownsfamiluclinic.com.au
Phone (07) 5391 3444 | Fax (07) 5391 3299
8 Fairfax St, Sippy Downs QLD 4556

Name: .... **Date of Birth**: ....

Do you have any known allergies? ☐ No ☐ Yes: .... ☐ Nil Known

Have you ever had an allergic reaction? ☐ No ☐ Yes: ....

Do you have any significant family history? ☐ Don't know ☐ No ☐ Yes - please complete details below:

☐ Diabetes ☐ Type 1 ☐ Type 2 Family Member: ....

☐ Cancer Type of Cancer: .... Family member: ....

☐ Heart Disease Family member: ....

☐ Hypertension Family member: ....

☐ Stroke Family member: ....

☐ Depression Family member: ....

☐ Other:..

Smoking: ☐ Non-smoker ☐ Smoker - how many/day: .. ☐ Ex-smoker - year stopped: ....

Alcohol: ☐ Non-drinker ☐ Drinker - how many days/week: ... How many std drinks/day: ....

Past Drinker: ☐ No ☐ Yes: ☐ Occasional ☐ Moderate ☐ Heavy

Year started (if known): .... Year stopped (if known): ....

What is your weight: .... **What is your height:** ....

Please list any medications that you are currently taking (including vitamins and herbal medicines):

Name of medication: .... Strength: .... Daily Dose: ....

Name of medication: .... Strength: .... Daily Dose: ....

Name of medication: .... Strength: .... Daily Dose: ....

Name of medication: .... Strength: .... Daily Dose: ....

Have you had any immunisations recently? ☐ Flu Vaccine ☐ Pneumococcal Vaccine ☐ Other - please state:

....

If child - are all childhood immunisations up-to-date? ☐ Yes ☐ No: ....

Do you have any significant past medical history? ☐ No ☐ Yes: ....

....

....

....

SIPPYDOWNS FAMILYCLINIC
Where your health comes first!

reception@sippydownsfamilyclinic.com.au
www.sippydownsfamiluclinic.com.au
Phone (07) 5391 3444 | Fax (07) 5391 3299
8 Fairfax St, Sippy Downs QLD 4556

CANCELLATION POLICY

Sippy Downs Family Clinic requests patients to cancel or rebook their appointments if they are unable to attend for any reason with no less than 4 hours' notice.

Your appointment time has been booked just for you. If you fail to cancel or rebook your appointment it causes issues for our doctors, allied health professionals and our other patients. It delays your treatment and prevents other patients from being offered an appointment.

Cancelled and missed appointment with less than 2 hours notice:

On any occasion will be charged with a $40 fee on their next visit or an invoice will be sent out.

Sippy Downs Family Clinic is not responsible for any reminder calls, except in certain circumstances. It is the patient's responsibility to remember and attend their appointment.

I have read and understood the Sippy Downs Family Clinic cancellation policy

Name of Patient: ………………………………………………………………………………………

Signature of Patient:………………………………………………………………………………

Name of parent/guardian/carer: ……………………………………………………………….

Signature of parent/guardian/carer:…………………………………………………….

Date: ……………………………………….