Professor Stan Sidhu
ENDOCRINE SURGEON
MBBS FRACS PhD

PATIENT INFORMATION FORM

Please complete both sides of this form

☐ MR ☐ MRS ☐ MISS ☐ MS ☐ DR OTHER:_____

SURNAME		
GIVEN NAME(S)		
DATE OF BIRTH		
HOME ADDRESS		
PHONE NUMBER	HOME:	WORK:
MOBILE NUMBER		
EMAIL ADDRESS		
NEXT OF KIN/EMERGENY CONTACT	NAME:	
	PHONE NO.:	RELATIONSHIP:
INTERPRETER	Do you require an interpreter? ☐ If ticked, please specify language: _____	
Are you of Aboriginal origin? ☐ Are you of Torres Strait Islander origin? ☐ Are you of Maori origin? ☐		
OCCUPATION		
MEDICARE/DVA NO **NAME AND POSITION (number next to your name)**	_____ EXP: _____/_____ _____ POSITION:_____	
PRIVATE HEALTH INSURANCE	☐ Yes ☐ No FUND NAME: _____ MEMBERSHIP NO.: ____ _____	

REFERRING DOCTOR DETAILS

GENERAL PRACTITIONER	REFERRING SPECIALIST (*IF APPLICABLE*)
NAME:	NAME:
ADDRESS:	ADDRESS:
PHONE NO.:	PHONE NO.:

How did you hear about Prof Stan Sidhu?

☐ Internet ☐ Referring Doctor ☐ Word Of Mouth ☐ Other

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HEALTH RECORDS & INFORMATION PRIVACY ACT 2002

The Health Records and Information Privacy Act 2002 require medical practitioners to obtain consent from patients for:

Collection – This means that we will collect information that is necessary to properly advise and treat you. Such necessary information may include:

- Full medical history
- Family medical history
- Ethnicity
- Contact details
- Genetic information
- Billing/account details
- Medicare and/or private health fund details

The information will normally be collected directly from you. There may be occasions when we will need to obtain information from other sources, for example:
Other medical practitioners, such as former GPs and specialists

- Other health care providers, such as pathology, physiotherapists, occupational therapists, psychologists, pharmacists, dentists, nurses
- Hospitals and Day Surgery Units

Both my staff and I may participate in the collection of this information. In emergency situations we may need to collect personal information from relatives or other sources where we are unable to obtain your prior express consent.

Use and Disclosure – With your consent, your information will be used and disclosed for purposes such as:

- Account keeping and billing purposes
- Referral to another medical practitioner or health care provider
- Claiming from Medicare and your health fund on your behalf when required
- Sending of specimens, such as blood samples or pap smears for analysis
- Referral to a hospital for treatment and/or advice
- Advice on treatment options
- The management of our practice in relation to bookkeeping, debt collection & taxation audit
- Quality assurance, including development of a data base for surveillance of treatment outcomes, practice accreditation, complaint handling and surgical audit
- To meet our obligations of notification to our medical defence organisations or insurers
- To prevent or lessen a serious threat to an individual's life, health or safety where **legally required to do so**, such as producing records to court, mandatory reporting of child abuse or the notification of diagnosis of certain communicable diseases.
- For medical student training where your medical information and age (not your name, address or phone number) would only be used for research projects and training of medical students
- For surgical research projects complying with strict protocols and approved by a Human Research & Ethics Committee- YOU WILL BE PROVIDED WITH SEPARATE INFORMATION SHEETS AND CONSENT FORMS TO READ AND SIGN

CONSENT

I,_____***(Patient Name in Full)*** provide my consent to Prof Stan Sidhu and staff to collect, use and disclose my personal information as outlined above.

I understand that I am entitled to access my own health records except where access would be considered unreasonable.

Apart from my referring doctor, I hereby permit my condition to be discussed with the another doctor, spouse or family member if indicated and may withdraw my consent as to use and disclosure of my personal information (except where legal obligations must be met).

Patient Signature:…… **Date**: ……..

Witness: ……

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MEDICAL QUESTIONNAIRE

*Please complete the following to the **best of your knowledge***
If you are unsure, please write "unsure"

Name:_____ **DOB:** _____

HEART CONDITIONS					
Do you have any **heart** conditions?			**Yes**		**No**
	Details				
	Yes? Are you on any **anticoagulant/ blood thinning** medications?				**No**
		Yes? *Details of Medication*			
	Do you have a cardiologist?				**No**
		Yes? *Name & Location*			

OTHER MEDICAL CONDITIONS			
Do you **have a history of or have**? *(tick)*		**Yes**	**No**
	Deep Vein Thrombosis (*DVT*)		
	Pulmonary Embolism (*PE*)		
	Diabetes Type 1/2		
Do you have any **other health conditions**?		**No**	
	Yes? *Please list*		
	Other treating specialists *Name/Location*		

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ANAESTHETIC INFORMATION				
Have you been under general anaesthetic before?	**Yes**		**No**	
Yes? Have you had any issues/problems? (*please describe*)				

OTHER REGULAR MEDICATIONS (please list)	
Name/Dosage	*Condition treating*
MULTIVITAMINS/FISH OIL/SUPPLEMENTS/HERBAL MEDICATION (*please list*)	
LIST OF ALLERGIES (*Includes food, latex, plaster, medication etc.**)***	

Do you have a history of anaphylaxis (*severe allergic reaction*)?	**Yes**		**No**	
Yes? *Name of substance*				