Patient Information Form

Patient Details

Please tick: ◯ **Mr** ◯ **Mrs** ◯ **Miss** ◯ **Ms**

Surname

Given Names *as on your Medicare card*

Address

Postal Address *if different to above*

DOB / / **Age** **Email**

Phone **Mobile** **Work**

Occupation **Employer**

Next of Kin **Ph/Mob**

Medicare No. **Ref. Code** **Exp. Date** /

Private Health Fund **Membership No.**

Pension or HCC No. **Exp. Date** /

Veterans' Affairs No. **Gold Card** ◯ YES ◯ NO

Medications *please attach separately if exceeding 3 lines*

Allergies

Reason for Attending

COLORECTAL SPECIALIST GROUP

Adelaide Liver Biliary & Pancreatic Specialists

Suite 209 Flinders Private Hospital
1 Flinders Drive Bedford Park SA 5042
P **8371 3077** - F **8293 2424**
www.colorectalsg.com.au

Patient Information Form

Referring Doctor

Referring Doctor's Name

Provider No.

Address

Phone

Fax

Local Doctor *if different from above*

Local Doctor's Name

Provider No.

Address

Phone

Fax

Preferred Surgeon

Doctor Request *please tick*

- ◯ Professor Robert Padbury
- ◯ Dr Dayan De Fontgalland
- ◯ Dr Tom Wilson
- ◯ Dr John Chen
- ◯ Dr Eu Ling Neo
- ◯ Dr Eu Nice Neo
- ◯ Dr Tiong Cheng (TC) Sia
- ◯ Dr Janina Kaczmarzcyk
- ◯ Dr Abdullah Rana

Person Responsible for Account

Name

Signature

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Your Privacy is Our Business

Understanding your rights and this practice's responsibilities under the health privacy legislation.

The collection of patient health information is essential for the provision of quality health care. Such information is confidential and can only be collected with your consent. You are entitled to know what personal information the practice holds about you, how and under what circumstances you may have access to that information, why it is held and to whom it may be disclosed and why.

In order to arrange tests and investigations, appointments with other medical or health specialists, and admission to hospital for surgery or procedures, some of your personal health information must be shared.

PRIVACY POLICY:

Consistent with our commitment to quality care this practice has developed a policy to protect your private health information in compliance with the 10 National Privacy Principles of the Federal Privacy Act.

1. It is necessary to collect personal information from patients and sometimes others associated with their health care to provide quality health care and for associated administrative purposes.
2. Health information is sensitive hence there is a requirement that patients consent to the collection of that information.
3. A patient's personal health information will be used or disclosed only for purposes that relate directly to their health care. There may be circumstances where disclosure of information may occur without consent such as emergencies, by law (eg mandatory reporting of some communicable diseases), for medical indemnity insurance obligations, provision of information may also be collected for audit purposes.
4. Information collected will be maintained in a form that is accurate, complete and up to date.
5. The storage and, if necessary, transfer of information will be undertaken in a secure manner.
6. On request, the practice will let patients know what sort of personal information is held, for what purposes and how or why it is collected, used or disclosed.
7. Patients may request access to their personal health information. Patients will have the opportunity to amend information that is incorrect. If legislation prevents access to information, the reasons will be explained.
8. Where identifiers (numbers, letters or symbols) are used to identify patients (eg Medicare numbers), their use will be limited to the purpose of fulfilling our obligation to the relevant Commonwealth Government agency.
9. A patient has a right to be dealt with anonymously where lawful and practicable, though this is not likely to be possible for Medicare and insurance rebate purposes.
10. Steps will be taken to protect patient privacy if information is to be sent interstate or outside Australia.

I have read and understood the Privacy Policy and the implications associated with the policy:

Print your full name _____

Signature _____ **Date** / /

I give my permission for _____
to give and obtain information regarding my medical state/issues.

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