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| C:\Users\tfilippone\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.Outlook\7MB59VO9\PGG_logo Hi RES.jpg  **Patient Information** |
| ❑ Miss ❑ Mrs ❑ Ms ❑ Dr ❑ Sr |
| Surname: Given Names:  Date of Birth: ­­\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_ Maiden name (if applicable):  Address:  Suburb: Post Code:  Home 🕿: Mobile: 🕿:  Email address:  Preferred method for correspondence and results, acknowledging that emails are not encrypted or 100% secure: ❑ Post / ❑ Email  Occupation:  Next of kin: Relationship to self:  Next of kin contact number: |
| Are you of Aboriginal or Torres Strait Islander Origin? ❑ Yes / ❑ No  Country of birth: |
| Medicare/DVA Card No: Card Ref No: Expiry Date: \_\_\_\_\_/\_\_\_\_\_\_  Health Fund Name: Membership No:  Health Insurance Level of Cover: ❑ Extras only ❑ Basic ❑ Bronze ❑ Silver ❑ Gold |
| Height: Weight:  Are you diabetic? ❑ Yes / ❑ No If yes, type: ❑ Insulin Dependent / ❑ Non-Insulin Dependent  Do you take the following medication(s): Forxiga (Dapagliflozin) ❑ Yes / ❑ No  Jardiance (Empagliflozin) ❑ Yes / ❑ No  Xigduo/Jardimet (Canagliflozin/Metformin) ❑ Yes / ❑ No  If you answered “yes” to any of the above medications, these **MUST** be stopped 3 days prior to any general anaesthetic inpatient procedure (which may be required to be performed), otherwise the procedure will be cancelled and rescheduled. (Any procedures at the time of consultation are not performed under a general anaesthetic).  Do you take blood thinners? ❑ Yes / ❑ No If yes, medication and dose:  If you answered “yes” to any of the above medications, these **MAY** need to be stopped 2-5 days prior to any general anaesthetic inpatient procedure (which may be required to be performed), otherwise the procedure may be cancelled and rescheduled. (Any procedures at the time of consultation are not performed under a general anaesthetic).  Other medication(s):    Known allergies: |
| Name of doctor referring you to this practice:  Address:  Suburb: Post Code:  Name of local GP (if different to above):  Address:  Suburb: Post Code: |
| This practice is committed to ensuring high-level privacy for personal health information collected, used and disclosed in the course of effective patient care. During this process, both collection and sharing of health information with other treating practitioners will be necessary. Should my health information be required for purposes other than those listed above, I understand that my further consent will be required. Should it be necessary for me to be contacted for follow-up, I am happy for my name to be placed on a reminder system. |
| Name: Signature: Date: / / |