Western Australia
Oncology
Menopause
Endometriosis
New Mothers

PATIENT DETAILS SHEET

FIRST NAME _____ ◯ MR ◯ MRS ◯ MS ◯ MISS ◯ OTHER

SURNAME _____ DOB _____ /_____ /_____

ADDRESS _____

SUBURB _____ STATE _____ POST CODE _____

HOME PHONE _____ WORK PHONE _____ MOBILE _____

OCCUPATION _____ EMAIL ADDRESS _____

ARE YOU HAPPY TO RECEIVE CORRESPONDENCE VIA EMAIL? ---------- ◯ YES / ◯ NO

NEXT OF KIN _____ RELATIONSHIP _____PHONE NO._____

MEDICARE NO._____ REFERENCE ON CARD_____EXPIRY DATE_____

PRIVATE HEALTH FUND_____ MEMBERSHIP NO. _____

MEMBER OVER 12 MONTHS ---------- ◯ YES / ◯ NO

◯ HEALTH CARE ◯ PENSION ◯ DVA CARD NO. _____EXPIRY_____

REFERRING DOCTOR _____ ◯ SPECIALIST / ◯ GP REFERRAL

USUAL GP (If different from above) _____ USUAL GP PHONE NO._____

ADDRESS _____

ARE THERE OTHER MEDICAL PRACTITIONERS YOU WOULD LIKE CORRESPONDENCE TO BE SENT TO APART FROM YOUR REFERRING DOCTOR AND USUAL GP? PLEASE LIST:

NAME	ADDRESS	PHONE

1. Please note that the information supplied is confidential and patient privacy is always maintained.
2. I declare that all information written on the above form is true to the best of my knowledge.
3. Images may be captured and stored on your medical records during clinical examination and/or colposcopy examination to aide in documentation and treatment progress of clinical problems.
4. All images are de-identified. Should you not wish any images to be captured, please inform us.
5. Medical students may be present during examinations, if you do not wish this, please inform your doctor.
6. I consent for my medical information to be forwarded to other health professionals if necessary.

Sign _____Date _____/_____/_____

Submit