PATIENT INFORMATION DATA COLLECTION SHEET/CONSENT FORM

Patient information / Consent Form – City Eye Centre	
Title: First Name: Surname:	Date of Birth: Country of Birth: Primary Language:
Home Address: Suburb: State: Postcode:	
Home Phone: Work Phone: Mobile: Email:	**Who lives at home with you?** ☐ Family ☐ Friends ☐ Alone ☐ Retirement Village / Nursing Home
Current General Practitioner GP Name: Dr	Practice Name & Address:
Private Health Insurance: Hospital Cover: ☐ YES ☐ NO	Health Fund Name: Membership Number:
Medicare Number: Ref. No:	Expiry date: / /
Pension Card Number:	Expiry date: / /
Veteran's Affairs Number:	Expiry date: / /
Healthcare Card Number:	Expiry date: / /
Name of Next of Kin: Mobile Number: **Relationship to you:** ☐ Husband ☐ Wife ☐ Mother ☐ Father ☐ Sibling ☐ Other _____	

The information you have provided is required by the Practice in order to identify your medical record and provide an accurate, quality health service. With your consent the above information may be forwarded to other healthcare providers involved in the diagnosis, management and/or treatment of your medical condition and these may include pathologists or radiologists. It is imperative that accurate information is forwarded to these parties to ensure that correct patient identification is obtained. Failure to do so may result in a risk to your health. As part of the Practice Recall System, we may wish to contact you by telephone or mail in order to notify you of the need for follow-up of certain conditions. If you wish to know more about how your information is collected, managed and stored by this Practice, please ask one of our Receptionists for our updated City Eye Centre Privacy Policy Consent Form.

I agree to abide by the City Eye Centre Privacy Policy.

I have read the above and consent to my information being forwarded to providers involved in my healthcare. I confirm that I may be contacted by mail at the above address or by my preferred telephone number as indicated.

For your information, Medicare requires patients to have a current referral when seeing a specialist doctor in order for payments to be rebated. It is the patient's responsibility to ensure their referral is current at the time of the consultation.

For any urgent matters please DO NOT contact City Eye Centre via SMS, email or any other social media. For any urgent medical matters after hours, please contact the Eye Registrar at the Royal Brisbane Hospital.

Signed: …… Date: ……

Patient Signature or (nominated person) authorised to give consent

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PATIENT INFORMATION DATA COLLECTION SHEET/CONSENT FORM

Please complete this from which will assist with your appointment. If you have any questions please ask our medical or administration staff.

Name of Patient _____ **Age**_____

Occupation/Previous occupation _____

MEDICAL HISTORY:

Have you any known Allergies (eg. penicillin) ☐ Yes, please specify:_____ ☐ No

Please list history:

_____

_____

Are you being treated for or have you had: ☐High Blood Pressure ☐Diabetes ☐Asthma

☐Emphysema☐Heart Disease ☐Stroke☐ Epilepsy ☐ Other _____

MEDICATIONS:

Are you on any anti-coagulants? ☐ Yes, please specify: _____ ☐ No

Does your doctor and/or GP prescribe you taking medication(s)? If yes please list, or attach your list

_____

_____

SURGICAL HISTORY:

Have you had any major surgery in the past (eg. Pacemaker, Bypass Surgery, Joint replacement)

_____

EYE MEDICATION: **Are you using any Eye Medications (e.g. Drops, Ointments, Tablets)**

If so please list:

_____

EYE HISTORY: **Have you had any Eye Problems, Surgery, Laser, Treatments or Injuries?**

☐ Glaucoma ☐ Macular Degeneration ☐ Lazy Eye ☐ Turned Eye ☐ Eye Surgery ☐ Eye Injury

☐ Eye Laser ☐ Glasses ☐ Contact Lenses ☐ Other _____

FAMILY EYE HISTORY: **Are you aware if any of your Family (eg. Parents, Aunts, Uncles, Grandparents)**

Have had any eye problems:

☐ Glaucoma ☐ Detached Retina ☐ Macular Degeneration ☐ Cataracts ☐ Other _____

Signed: ……

Thank you for your time in completing this form.

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