City Eye Centre
OPHTHALMIC CONSULTANTS

New Patient Information
and Consent Form

We kindly request that you complete the form below before your appointment. This helps our clinical team prepare for your consultation.

1. YOUR DETAILS

Title | First name | Surname

Date of birth (DD/MM/YYYY) | Age | Country of birth | Primary language

Home address

Suburb | State | Postcode

Home phone | Work phone

Mobile | Email

Current or previous occupation

2. YOUR GP, OPTOMETRIST AND HEALTH COVER

Current general practitioner (GP) | Practice name and address

Current optometrist | Practice name and address

Do you have private health insurance with hospital cover? ○ Yes ○ No

Health fund name | Membership number

Medicare number | Ref | Expiry | **Pension card number** | Expiry

Veterans' Affairs number | Expiry | **Healthcare card number** | Expiry

3. EMERGENCY CONTACT

Next of kin - name | Mobile number

Relationship to patient

☐ Husband ☐ Wife ☐ Son ☐ Daughter ☐ Mother ☐ Father ☐ Sibling ☐ Other

Who do you live with?

☐ Alone ☐ Spouse or partner ☐ Family or relatives ☐ Friends

☐ Retirement village or independent living ☐ Residential aged care or nursing home

4. MEDICAL AND EYE HISTORY

Do you have any known allergies (e.g. penicillin or sulfonamide ("sulfa") antibiotics)? Yes No

If yes, please provide details

Have you ever been diagnosed with or treated for any of the following?

Diabetes **Type:** Type 1 Type 2 Unsure **Currently using insulin:** Yes No

High blood pressure Asthma Lung disease Heart disease Prostate issues

Other medical condition - please specify

Are you taking any anticoagulant or blood-thinning medication? Yes No

If yes, please provide details

Current prescribed medications - list below or attach a current medication list

Major surgery or procedures (e.g. pacemaker, bypass surgery or joint replacement)

Current eye medications, including drops, ointments or tablets

Have you had any eye problems, surgery, laser treatment, other treatments or eye injuries?

Cataract Glaucoma Macular degeneration Lazy eye Turned eye

Eye surgery Eye laser Eye injury Glasses Contact lenses Other

If other, please specify

Family eye history - are you aware of eye problems affecting members of your family?

Glaucoma Detached retina Macular degeneration Cataracts Other

5. PRIVACY AND CONSENT

The information provided in this form is required to identify your medical record and provide safe, high-quality care. With your consent, it may be shared with healthcare providers involved in your diagnosis, management or treatment, including pathologists and radiologists, to ensure correct patient identification and continuity of care.

As part of our Practice Recall System, we may contact you by SMS text message or email regarding follow-up care. For information about how your information is collected, managed and stored, please ask reception for the current City Eye Centre Privacy Policy. Medicare requires a current referral for specialist consultations to be eligible for a rebate. It is the patient's responsibility to ensure their referral is current at the time of consultation. For urgent matters, do not contact City Eye Centre via SMS, email or social media. For any urgent medical matters after hours, contact the Eye Registrar at the Royal Brisbane Hospital or the St Andrew's Hospital Emergency Centre.

I acknowledge that I have read and understood the City Eye Centre Privacy Policy.

I consent to my information being shared with healthcare providers involved in my care and to City Eye Centre contacting me by SMS text message or email using the contact details provided above.

Patient signature, or signature of a person authorised to provide consent

Date