The Sleep Cottage – Paediatric Practice & Sleep Laboratory

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Please indicate which Doctor attending:

☐ **Dr Virginia Oliveira** ☐ **Dr Natalie Gentin**
☐ **Dr Doreen Hershco** ☐ **Dr Martina Popelkova**

NEW PATIENT INTAKE FORM – *page 1 of 2*

Surname of child:____

Given Names: ____

Known as: ____

DOB:____/____/_______ **Gender: Male / Female / prefer not to say / Other** ____________

Aboriginal / Torres Strait origin? Yes / No / prefer not to say

Address: ____

____ **Post Code:** ____________

***Mobile:**________________________ **Home Phone:** ____________________
*(*This mobile will be used for SMS confirmation of appointments)*

E-mail: ____

Parent 1 Surname:____________________**Given Names:** ____________________

***Parent 1 DOB:**____/____/_______*(*required for Medicare electronic identification)* **One parent on form is OK**

Title: Mr / Mrs / Ms / Dr / Other:____________**Relationship to child:** ______________

Parent 2 Surname:____________________**Given Names:** ____________________

***Parent 2 DOB:**____/____/_______ **Parent 2 Mobile:** ________________________

Title: Mr / Mrs / Ms / Dr /Other:____________**Relationship to child:** ______________

Parent 2 E-mail: ____

Medicare Number:____________ ______________ ___**Expiry:**________/_______

Medicare card reference Number - Child: ________ **Parent 1:** ________ **Parent 2:** _______

Health Fund:________________ **Member Number:** ____________________

CONSENT FORM – *page 2 of 2*

While we take every reasonable step to safeguard your details, we may disclose confidential information regarding your child under the following circumstances:

- **With your direct consent;**
- **If there is an immediate and specific risk of harm to the child / to others;**
- **Where there is a legal obligation to do so, such as harm to oneself, harm to others, child neglect/abuse, or mandatory reporting; and**
- **When consulting colleagues, or in the course of professional supervision.**

I__________________________________parent/ carer of __________________________________ consent to the collection and release of all necessary and pertinent information regarding this patient to the following parties (Provide Name, Suburb & Phone Number below**):**

- **General Practitioner ____**
- **Paediatrician ____**
- **Specialist ____**
- **Allied Health Professionals:**

  Speech pathologist ____

  Occupational therapist ____

  Psychologist ____
- **Other ____**
- **School / Preschool ____**
- **Day Care ____**

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FINANCIAL CONSENT and CANCELLATION FEES

- **I understand that if I give less than 48 hours notice of cancellation, or do not attend a confirmed appointment there will be a cancellation fee issued to me equal to the fee of the consult. This fee must be paid before any further appointments will be made.**

Name:____ Date: ___________________

Signature: _______________________________________