CONFIDENTIAL PATIENT INFORMATION FORM

Mr / Mrs / Miss / Ms / Other_____________________(please circle/specify)

Surname___________________________________Given Name ____

Address ____

Postcode________________Email ____

Phone: (H)___________________________(M)______________________________(W) _______________________

Date of Birth____________________________Occupation ____

Referring Doctor and Address ____

GP name and address (if different to referring doctor) ____

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Other Medical Specialists ____

Medicare No.__________________________________Patient No.____________Expiry _______________________

Private Health Insurance ________________________________Membership No. _____________________________

Pensioner/Health Care Card____Expiry ______________________

Veterans Affair No. (if applicable) ____

Previous Pathology Company ____

Regular Chemist & Address ____

I consent to my doctor prescribing my script(s) electronically through eRx script exchange (please tick) □ Yes □ No

Due to current privacy laws, all patient information is confidential. If you wish any information to be shared with a relative or other person, please record name and relationship. By nominating another person, it advises us that you consent to confidential information to the person named below.

Name_______________________________Relationship______________________Phone ______________________

We may need to obtain old results and reports from your treating doctors and hospitals – if you are happy for us to do so, please sign below. I authorise Dr Margaret Fraenkel, Dr Sid Rajakumar, Dr Darren Lee, Dr Louis Huang, Dr Vatsa Dave, Dr Dov Degen, Dr Jia Yee (Vivian) Mah to obtain results from my treating doctors/pathology/hospital records and have no objection to my letters/results being transmitted via email for expediency.

Name_____________________________ Signature__________________________________Date ______________

Eastern Nephrology | Epworth Eastern Medical Centre
Suite 7, 120 Thames Street, BOX HILL NORTH 3129

Phone: 9895 7641 | Fax: 9895 7612
E: info@easternnephrology.com.au

Name:________________________________

Date of Birth: ______ / _______ / ________

Phone: _______________________________

MEDICATION LIST

	MEDICATION	NOTES
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Additional Notes (if any):

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