RESIDENTIAL AGED CARE FACILITY

TITLE_____**FIRSTNAME**_____**MIDDLENAME**_____**SURNAME**_____

PREFERRED NAME_____**DATE OF BIRTH**_____**SEX**: M/F **GENDER**: Male/Female/Non-Binary

DO YOU IDENTIFY AS ATSI: YES / NO **Aboriginal / Torres Strait Island/ Both**

MARITAL STATUS: Single / Married / Widowed / Divorced / De facto / Separated

OCCUPATION:_____**LOCATION IN FACILITY E.G. WARD/BED NO.** _____

CONTACT DETAILS:

ADDRESS:_____

TOWN/CITY_____**POSTCODE**_____**STATE**_____

POSTALADDRESS (if different from above)
_____**POSTCODE**_____**STATE**_____

CONTACT NUMBERS:

Primary Contact Name_____**Mobile** _____

Secondary Contact Name_____**Mobile** _____

Facility Contact Number _____

Primary Email Contact_____

Please circle as appropriate:

Can we contact you via SMS: **Yes/No** Can we contact you via EMAIL: **Yes/No** Do you participate in My Health Record: **Yes/No**

NEXT OF KIN	
Name:	Date of Birth:
Relationship to you:	
Mobile:	Email:

MEDICARE NO: **REF NO.** 1 2 3 4 5 6 7 8 9	**EXPIRY DATE:**
NOMINATED PAYER: Self Mother Father Other – Name:	
CONCESSION CARD: Yes / No **Type –** Pension / Health Care / Commonwealth Seniors / Veteran Gold / Veteran White (list condition)	
CARD NUMBER:	**EXPIRY DATE**:

HOSPITAL COVER: Yes/No Fund Name: **Type:** Basic / Intermediate /Top

INFORMATION PROVIDED TO WARWICK ROAD MEDICAL	
YES/NO	Do you have an Enduring Power of Attorney? If so, please send a copy to Warwick Road Medical
YES/NO	Discharge Summary (if applicable)
YES/NO	Please provide the name of your pharmacy for ongoing script management.
YES/NO	We will send a request for records to your previous community GP, please provide their name.
YES/NO	Do you have an Advance Health Directive? If so, please send a copy to Warwick Road Medical

PLEASE RETURN THIS FORM VIA EMAIL - admin@warwickroadmedical.com.au
OR IN PERSON AT WARWICK ROAD MEDICAL - 70 WARWICK ROAD IPSWICH
PHONE: 07 3447 0402

CONSENT FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION: *Warwick Road Medical have a legal and ethical duty to protect patient information under The Privacy Act 1988. I consent to the use of my personal health information by the above-named practice and other health providers involved in my medical treatment and health care. I consent to the disclosure of my personal health information by the above-named practice to other health providers directly or indirectly involved in my personal health care or medical treatment. I understand that the Doctors within the Practice are qualified General Practitioners.*

I have read and understand the overview of Data Sharing Policies used by Warwick Road Medical - ***YES / NO***

NAME _____ **DATE** _____

SIGNATURE _____

ENDURING ASSIGNMENT OF BENEFIT - MYMEDICARE REGISTRATION:

I understand that registration with MyMedicare is a requirement of Dr Walker's service and I give consent for Dr Walker to complete this registration process on my behalf. I understand this program is voluntary and I can transfer my registration to another provider at any stage. I understand that I may not be eligible for bulk billed services if I am not registered as one of Dr Walker's patients under the MyMedicare program.

I acknowledge Enduring Assignment of Benefit for the purpose of Bulk Billing ongoing care. ***YES / NO***

Further information can be found here: https://www.health.gov.au/our-work/mymedicare/patients

NAME _____ **DATE** _____

SIGNATURE _____

FINANCIAL DISCLOSURE STATEMENT - I am aware that the doctors at Warwick Road Medical bulk bill their patients who reside in aged care facilities. I willingly assign my Medicare rebate to the treating doctor for each rebatable service. The services provided include, but are not limited to, face to face consultation, telephone consultation with support staff and family, medication management, review and ongoing prescribing, consultation and referral to third party providers such as pathology and relevant specialists, A/H care and advice to facility staff for ongoing medical care. I understand that the introduction of additional care providers, such as other GPs and third-party providers waive my access to bulk billed services. I am aware that some medical services do not attract a Medicare rebate and I will be required to pay a private invoice. I am aware that some services require attendance to the doctor's rooms and I am aware of the Cancellation and Fail to Attend Policies and understand my obligations for notice in advance. I am aware that regulations are prone to change, and I accept the associated costs of those changes

NAME _____ **DATE** _____

SIGNATURE _____

YOU CAN FIND THE PRACTICE POLICIES ON THE WEBSITE - https://warwickroadmedical.com.au/policy-page