WARWICK RD MEDICAL

RESIDENTIAL AGED CARE FACILITY

TITLE______**FIRSTNAME**_________________**MIDDLENAME**_________________**SURNAME**__________________________________

KNOWN AS (Nickname)__________________**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:**________________________________

CONTACT DETAILS:

HOMEADDRESS:____

TOWN/CITY____**POSTCODE**_______________**STATE**_______________________________

POSTAL ADDRESS (if different from above)
____**POSTCODE**______________**STATE**___________________________________

CONTACT NUMBERS:

Home ____ **Mobile** ____

Work ____**Fax**____

Email ____

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:	
Address:	
Phone Number (Home):	Mobile:

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	Enduring Power of Attorney
YES/NO	Discharge Summary (if applicable)
YES/NO	Pharmacy Details
YES/NO	Previous Medical History
YES/NO	Advanced Health Directive

CONSENT FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION: *Warwick Road Medical hae 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.*

DATA SHARING CONSENT:

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

NAME	**DATE**
SIGNATURE	**DOB**

Note: Referrals to medical specialists/hospitals require patient information to be correct and current. If your details are not up to date, there may be a delay in the referral process. Please take the time to complete the following to ensure a prompt timely response.

WARWICK ROAD MEDICAL - DATA SHARING POLICY - OVERVIEW

When will we share your data?

In the management of your treatment -

WRM will share relevant personal health information with other health providers involved in your medical care. We utilize secure messaging services and fax. Our practice policy precludes the use of email unless no other options are available.

This consent is signed for on your New Patient Registration Form under "Consent for Use and Disclosure of Personal Health Information"

In participation with MyHealth Record –

At the close of each quarter WRM uploads a selection of records to the MyHealth Record Database. These are selected at random and the number varies in accordance with the demands of the Department of Health.

If you have an active MyHealth Record and DO NOT want us to upload records, please advise the staff at reception. You may be asked to put this request in writing.

In participation with the PIP QI –

As a practice, Warwick Road Medical obtains informed consent prior to sharing your data with the Primary Health Network. All patients of Warwick Road Medical are automatically opted OUT of this data sharing agreement. After reading the overview of the PIP QI, if you would like to be opted in, please advise the staff at reception who will ask you to sign a consent form.