|  |  |  |
| --- | --- | --- |
| **Patient Information** |  |  |
| Full Name |       | Gender [ ] Female |  [ ]  Male |
| Date of Birth |       |  |  |
| Home Address |        | Postal Address |       |
| Phone |       | Email       |  |

|  |  |
| --- | --- |
| **Referring Doctor**  | **Physiotherapist**  |
| Name:       | Name:       |
| Address:        | Address:       |
| Phone:       | Phone:       |

|  |  |
| --- | --- |
| **Family GP** | **Next of Kin** |
| Name:      Address:      Phone:       | Name:      Relationship:      Phone:       |

|  |  |
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| **Medicare**  | **Health Fund** |
| Card number:        | Name of the fund:       |
| Reference number:       Expiry date:       | Membership number:       |

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| **Is this consultation in regard to a worker’s compensation claim?** |
| Name of employer:       |
| Contact person:       | Phone:       |
| Insurance company:       | Claim number:       |

[ ]  I consent for my medical records to be released for the purposes of my treatment.

[ ]  I consent for information about me to be released appropriately for clinical research.

[ ]  I consent for my clinical photographs to be taken appropriately as part of my clinical record.

[ ]  I consent for my clinical photographs to be used for medical and patient education purposes. I understand that images may be seen by members of the general public. Although these photographs will be used without identifying information such as my name, I understand that it is possible that someone may recognize me.

|  |  |
| --- | --- |
| Signature:   | Date:       |