|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **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: |

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

|  |  |
| --- | --- |
| **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: |