SouthWest
BREAST CLINIC

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# Patient Information Form

Title: ☐ Mr ☐ Mrs ☐ Ms ☐ Dr ☐ Prof ☐ Other _____

Given Name: _____ Surname: _____

Preferred Name: _____ Date of birth _____

Address: _____ Suburb: _____ Postcode _____

Email: _____ Phone: (H) _____ (W) _____ Mobile: _____

Weight: _____ Height: _____

Medicare No. ☐☐☐☐☐☐☐☐☐☐ Ref No. ☐ Expiry Date ☐☐ / ☐☐☐☐

Dept. Veterans Affair Card No: _____ ☐ White ☐ Gold Expiry Date _____

Concessions: ☐ None ☐ Pensioner Entitlements No. _____ Expiry Date _____

**Private Health Insurance:**

☐ Yes ☐ No Fund: _____ Fund Number: _____

Hospital Inpatient Cover: ☐ Yes ☐ No

Who is responsible for your account?

☐ Self ☐ Parent ☐ Vet Affairs ☐ Workers Compensation ☐ MVIT

**Next of Kin Details/ Emergency Contact Name**

Name: _____ Relationship to you _____

Contact number: _____

**Referral Source**

☐ Self ☐ Doctor-GP ☐ Specialist ☐ Emergency department

Referring Doctor: _____ Date of referral: _____ Usual GP: _____

**Do you have/or have had any of the following conditions or illnesses**

Have you taken oral conception pill or implant? ☐ Yes ☐ No How long: _____

How many pregnancies have you had? _____

Age of first pregnancy? _____

How many babies have you had? _____

Have you breast feed? ☐ Yes ☐ No How long: _____

Have you receive hormone replacement therapy? ☐ Yes ☐ No Type: _____

Do you have a family history of breast cancer? ☐ Yes ☐ No Who: _____

Do you have a family history of ovarian cancer? ☐ Yes ☐ No Who: _____

Any previous breast procedures? ☐ Yes ☐ No What: _____

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Allergies ☐ Yes ☐ No Type: _____

Cancer related illness ☐ Yes ☐ No Type: _____

Diabetes ☐ Yes ☐ No Type: _____

Do you drink alcohol? ☐ Yes ☐ No Number per day: _____

Do you smoke cigarettes? ☐ Yes ☐ No Number per day: _____

Have you ever smoked? ☐ Yes ☐ No If yes, when did you stop: _____

Do you use or have you used recreational drugs? ☐ Yes ☐ No Type: _____

Frequency: _____

Do you have, or have you been at risk of AIDS or hepatitis? ☐ Yes ☐ No Type: _____

Are you taking any prescription medication? ☐ Yes ☐ No Type: _____

Are you taking any herbal medications? ☐ Yes ☐ No Type: _____

Do you have illnesses that run in your family? ☐ Yes ☐ No

Describe:

Do you have any family history of heart disease? ☐ Yes ☐ No

Describe:

Any other medical conditions? ☐ Yes ☐ No

Describe:

**Privacy Policy**

The Privacy Act 1988, amendments proclaimed December 200 I , requires medical practitioners to obtain consent from their patients to collect, use and disclose the patient's personal information. Your information will be transferred electronically to the surgeon as required.

**Collection.**

This means we will collect information that is necessary to properly advise and treat you. Such necessary information may include:

- Full medical history, family medical history
- Ethnicity and genetic information
- Contact details
- Medicare, private health fund details and details for the issue of bills and accounts.

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This information is normally collected directly from you. There may be occasions when we need to obtain information from other sources, for example:

- Other medical practitioners such as former or current GP's and specialists
- Other healthcare providers such as physiotherapists, occupation therapists, pharmacists, nurses and dentists
- Hospital and day surgery units.

Our practice staff and medical practitioners may participate in the collection of this information. In emergency situations, we may need to collect personal information from relatives or other sources where we are unable to obtain your prior express consent.

**Use and Disclosure**

With your consent, the practice staff will use and disclose your information for purposes such as:

- Including account keeping and billing purposes
- Referral to another medical practitioner or healthcare provider
- Sending specimens such as blood samples, biopsies of skin or organs for analysis
- Referral to a hospital for admission or other treatment options
- Management of this practice
- Quality assurance, practice accreditation and complaint handling
- To meet our obligations of notification to our medical defence organisations or insurers
- To prevent or lessen a serious threat to an individuals life, health or safety.
- Photographic library may be used for record, teaching and educational purposes.

Where legally required to do so, this practice must, without your consent, provide health information such as providing records to court, or notification of diagnosis of certain communicable diseases to the Health Department.

This practice may also without your consent, utilise your health information for purposes such as:

- Research relevant to public health or public safety
- The compilation or analysis of statistics relevant to public health or public safety
- The management, funding or monitoring of our health service.

In these instances, reasonable steps will be taken to de-identify the information before it is disclosed.

**Access**

You are entitled to access your own health records at a time convenient to both yourself and the practice.
Access can be denied where:

- To provide access would create a serious threat to life or health
- There is a legal impediment to access
- Your request is frivolous
- The information relates to anticipated or actual legal proceedings, and you would not be entitled to access the information in those proceedings
- In the interests of national security.

Your request must be in writing. A charge of $100.00 will apply for photocopying and for staff time involved in the processing of your request. Where you dispute the accuracy of the information we have recorded, you are entitled to correct that information. It is our practice policy that we will take all steps to record all your corrections and place them in your file, but not erase the original record.

You will be asked to consent to the practice of Breast Cancer Clinic to collect, use and disclose your personal information as outlined above. You are entitled to access your own health records, except where access would be denied as outlined above. You may also withdraw your consent to the use and disclosure of your personal information, except where legal obligations must be met.

**I consent to images taken during my consult to be used anonymously for advertising and educational purposes.**

☐ **Yes** ☐ **No**

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**Patient's Acknowledgment**

I have read this form and understand:

- Why collecting information about me is necessary.
- I am not obliged to provide any information requested to me.
- My failure to provide this information may restrict the practice's ability to provide the quality of health care and treatment that I want.
- I have the right to access the information collected about me, except in some circumstances where access might legitimately be withheld. Fee's may be applicable for the collection of such information and adequate ID is required to receive this information.
- If my information is used for any other purpose other than set out above, my further consent will be obtained.
- I have the right to used an alternative name/pseudonym and are aware this can be impractical for Medicare purposes and accessing my medical history.

I am responsible for my accounts until settled in full (by myself or my health fund). The information you give to us is essential for administration, investigations, management of your health and audit purposes. This information will be kept confidential in electronic format and will not be used for any other purpose or released to any individual or organisation, from that otherwise stated without your written consent as per the practice privacy policy displayed.

**I understand that any gap payment not covered by my health fund or any surgical procedure will be paid by myself prior to my surgical date.**

**I acknowledge that I have read this form before signing it and that a member of staff has clarified any aspects I have not fully understood.**

I consent to the handling of my information by this practice for the purposes set out above.

I acknowledge that I have read this form before signing it and that a member of staff of this practice has at my request clarified any aspects of it that I did not understand.

Patient Name: _____ Signature: _____

Date: _____