North Shore Cardiac Centre

PATIENT INFORMATION & CONSENT FORM

Thank you for completing this form. All information is handled in accordance with strict confidentiality and privacy requirements.

PATIENT DETAILS

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

Given name: _____ **Middle name:** _____

Surname: _____

Date of birth: ____ / ____ / _____

Address: _____

Suburb: _____ **Postcode:** _____

Phone (home): _____ **Mobile:** _____

Email: _____

Health Cover & Identification

Private health fund: _____ **Member no.:** _____

Medicare no.: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ **Ref no.:** _____

Expiry: _____ / _____ **Pension no.:** _____

DVA card no.: _____ ☐ Gold ☐ White

Emergency Contact

Name: _____ **Relationship:** _____

Phone: _____

Consent

I consent to correspondence, reports, test results, and discharge summaries being shared with doctors, specialists, and hospitals involved in my care.

Patient name: _____ **DOB:** _____ / _____ / _____

Signature: _____ **Date:** _____ / _____ / _____

Billing notice: Fees are payable on the day. A valid referral is required to receive a Medicare rebate.

Doctors (referring and regularly involved in your care)

Referring doctor: _____ **Phone:** _____

GP: _____ **Phone:** _____

Other Specialists: _____

MEDICAL HISTORY - Medical Conditions (tick all that apply)

☐ Heart disease ☐ High blood pressure ☐ High cholesterol ☐ Stroke/TIA

☐ Kidney disease ☐ Lung disease ☐ Asthma ☐ Sleep apnoea

☐ Diabetes ☐ Thyroid disease ☐ Rheumatic fever ☐ Gout

☐ Stomach/duodenal ulcer ☐ Hepatitis/liver disease ☐ Bleeding disorder

☐ Cancer (type): _____ ☐ Other _____

Recent cardiac related Hospital Admissions: Hospital: _____Date: _____

Smoking History: ☐ Never ☐ Current ☐ Past

Family History

☐ Heart disease, high blood pressure, or stroke under age 75

Details (if yes): _____

Medication Allergies (and the reaction experienced)

Current Medications (including over the counter and supplements)

Medication	Dose	Strength (mcg/mg)

Thank you for completing this form.