To enable us to organise an appropriate appointment for you we ask that you complete the enclosed Patient Detail Questionnaire and return to our office as soon as possible. If not previously forwarded, please include the following:

- GP Referral
- X-Ray or Scan Reports (Films are not required at this point)

Please bring your films on the day of your appointment.

The above forms can be mailed, faxed or emailed to our office.

Current address: Dr John Albietz
QCOS Orthopaedic
Suite 14 Level 10
Evan Thomson Building
24 Chasely Street
Auchenflower Qld 4066

Fax: 07 3721 8666

Email: admin@qcos.net.au

The information received will be reviewed by Dr Albietz and we will contact you by mail within 7 working days with an appointment date and time.

Thank you for your understanding and co-operation. If you have any further questions please do not hesitate to contact our office on 07 3721 8600.

DATE: ____/____/ ____ JA

Title: Mrs Miss Ms Mr Mast Dr

Family Name: ______________________ Given Name: ______________________

Address: ______________________

Date of Birth: ____/____/____ Occupation: ______________ Email: ______________

Ph: (h) ______________ (w) ______________ Mobile ______________

Medicare No: ☐☐☐☐ ☐☐☐☐☐ ☐ Exp date: ______________

Medicare Reference Number (Small Number in front of your name): ☐

Dept Of Veteran Affairs No: ______________ Exp: _____/_____/_____ ☐ Gold Card / ☐ White Card

Health Care Card / Pension No: ______________ Exp: _____/_____/_____

Are you a member of a Private Health Fund: Yes / No

Health Fund: ______________ Membership No: ______________

Level of Cover (Please tick): ☐ Full Private Hospital ☐ Extras Only

Have you served the 12 month waiting period Yes / No

ACCOUNT PAYMENT DETAILS

☐ Self

☐ Workcover Claim No: ______________

Company/Employer ______________

☐ Other Details: ______________

REFERRAL DETAILS

Referring Doctor Name: ______________

Address: ______________

Usual GP ***(If different from referring doctor)*** ______________

Address: ______________

NEXT OF KIN DETAILS

Next of Kin: ______________ (Relationship) ______________

Address: ______________

Phone: ______________

PATIENT CONSENT

I give permission for you to disclose to any doctor, health authority, allied health provider, rehabilitation provider, Workcover Insurer and its agents, or other insurer any information about my medical history relevant to my treatment.

Signature: ______________ Date: ______________

X-RAYS

The QCOS Orthopaedic does not store x-rays / scans for any period of time exceeding twelve months. It is essential that you keep the scans in your possession at all times.

I hereby understand that the QCOS Orthopaedic will destroy any x-rays or scans left in their possession after twelve months, without prior notice.

Signature: ______________ Date: ______________

Patient Health Questionnaire

Patient Name: ____________________ DOB: ____________

Do you currently smoke? ☐ Yes ☐ No

Are you an ex smoker? ☐ Yes ☐ No

1. **Do you have a history of:**

		Please specify:
Deep Vein Thrombosis (DVT)	☐ Yes ☐ No	
Pulmonary Embolism (PE)	☐ Yes ☐ No	
Blood Clotting Disorders	☐ Yes ☐ No	
Do you have a family history of DVT or PE	☐ Yes ☐ No	
Arthritis (Osteo, Rheumatoid, Gout etc)	☐ Yes ☐ No	

2. **Please list any current or previous medical problems.**

1.
2.
3.
4.

3. **Have you had any previous operations?** ☐Yes ☐ No

Operation	When (Year)	Doctor
1.		
2.		
3.		
4.		

4. **Are you taking any of the following medications?**

If yes, please discuss with your doctor

- Plavix, Clopidgrel, Wafarin, Aspirin, Cartia ☐Yes ☐ No
- Hormone Replacement ☐Yes ☐ No
- Oral Contraceptives ☐Yes ☐ No

5. **Please list all other medications.**

Medication: *eg Panadol*	Dose: *eg 1 gram*	Frequency: *eg 4 per day*	Route: *capsule*

6. **Please list any allergies**

Medication / Substance	Reaction

7. **Have you had any other back/neck complaints:**

1. ____

2. ____

Patient Name: ______________________________ DOB: ______________

Do you have a current legal claim regarding this condition? ☐ Yes ☐ No

Are you seeing a Solicitor for this condition? ☐ Yes ☐ No

Will you need a legal report? ☐ Yes ☐ No

Is your problem: ☐ Scoliosis ☐ Other

If other, please give details: ______________________________

Height: (cm) ______________

Weight (kg) ______________

What date did the injury occur? ______________________________

How did the injury occur? ______________________________

Have you had any previous treatment with regards to this injury? Eg: Physiotherapy, Chiropractic, Occupational Therapy, Psychology, Injections, Pain Medication, Acupuncture etc.

____

If you have had any of the above treatment, when did it commence and how often have you been having treatment?

____

Have you seen any other Specialists with regards to this injury?

☐ Yes Name of Specialist/Specialists ______________________________

☐ No

Have you had any x-rays, CT scans or MRI's taken with regards to this injury?

☐ Yes

Please list the tests that you have had: ____________________

☐ No

Are you currently working?

☐ Yes

☐ No How long have you been off work? ____________________

WorkCover Patients Only

WorkCover Claim No: ______________________

WorkCover Claim Manager: ______________________ Ph: ______________________

Employer Name: ______________________

Employer Phone No: ______________________

Before this accident, did you have any condition or injury that affected this part of your body?

____

____

Have you had any other previous WorkCover claims?

____

____

WorkCover Patients Only

Important Information

It is very important that your WorkCover Medical Certificates are kept up to date at all times. Please request a new certificate from your doctor at each appointment, if required.

Your consultations will only be paid by WorkCover if they hold a current Medical Certificate.

It is the patient's responsibility to give a copy of the Medical Certificate to WorkCover and the Employer. This certificate is also to be given to anyone that is providing treatment eg: Physiotherapist, Chiropractic, Occupational Therapist, Hand Therapist etc

A current referral must be held by our office at all times.

Medical Certificates will not be issued over the phone.

Signature: ______________________ Date: ______________________