

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
- Any reports of xrays or scans

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 Simon Gatehouse  
QCOS Orthopaedic  
Evan Thomson Building  
Suite 14 Level 10  
24 Chasely Street  
Auchenflower Qld 4066

Fax: 07 3721 8666

Email: [admin@qcos.net.au](mailto:admin@qcos.net.au)

The information received will be reviewed by Dr Gatehouse 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: \_\_\_\_/\_\_\_\_/\_\_\_\_

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

#### 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: \_\_\_\_\_

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#### 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 Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Do you currently smoke? Yes / No

Are you an ex smoker? Yes / No

1. Please list any current or previous medical problems

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_
- 5. \_\_\_\_\_

2. Have you had any previous operations? Yes / No If Yes, please list:

Operation	When (Year)	Doctor

3. Please list all your current medications

Medication	Dose	Frequency	Route
<i>eg Panadol</i>	<i>1gram</i>	<i>4 x / day</i>	<i>capsule</i>

4. Please list any allergies

Medication / Substance	Reaction

5. Have you had any previous back/neck complaints:

1. \_\_\_\_\_

2. \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

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

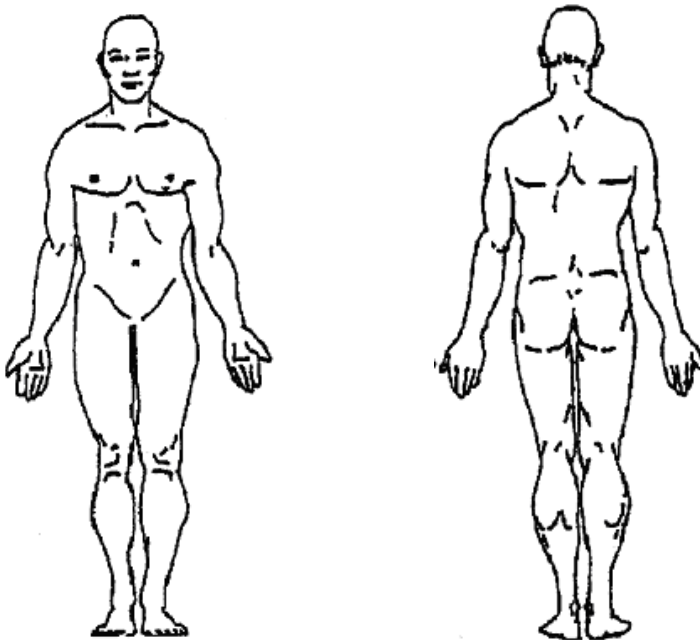
Are you seeing a Solicitor for this condition?  Yes  No

Will you need a legal report?  Yes  No

**Please indicate on this diagram where your pain is located.**

Mark areas of pain using shading.

Mark areas of tingling or pins and needles with crosses.



Please mark your current level of neck pain on the scale below.

0 is no pain and 10 is the worst pain imaginable.

|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|

0 1 2 3 4 5 6 7 8 9 10

Please mark your current level of arm pain on the scale below.

0 is no pain and 10 is the worst pain imaginable.



Office Use Only

\_\_\_\_\_/\_\_\_\_

\_\_\_\_\_%

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

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? \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**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: \_\_\_\_\_

