

To enable us to organize 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
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 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: ____/____/____

SG

Title: Mrs Miss Ms Mr Mast Dr

Family Name: _____ Given Name: _____

Address: _____

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

Ph: (h) _____ (w) _____ Mobile _____

Medicare No: Exp: _____

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: _____

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

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? _____

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: _____

