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: ______________________________

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

SMS Message Reminder ☐ Yes ☐ No

Dept. Of Veteran Affairs No: _________________Exp: _____/_____/______ ☐Gold Card / ☐White Card

Health Care Card / Pension No: ______________________________ Exp:______/______/______

HEALTH FUND DETAILS

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

Health Fund: ______________________________ Membership No:______________________________

Level of Cover: ☐ 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: ______________________________

PHYSIOTHERAPIST

Name: ______________________________

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

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 any x-rays or scans left in their possession after twelve months, will be destroyed, 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:
Diabetes	☐ Yes ☐ No	
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

Patient Name: ______________________________ DOB: ______________

WorkCover Claims

Name: ______________________________ **DOB:** ______________

WorkCover Claim No: ______________________________

WorkCover Claim Manager: ______________________________ **Ph:** ______________

Employer Name: ______________________________

Employer Phone No: ______________________________

Height: (cm) ______________________________

Weight: (kg) ______________________________

What date did the injury occur? ______________________________

How did the injury occur? ______________________________

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

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?

Patient Name: ____ DOB: ___________________

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? ____

Have you had any other previous WorkCover Claims:

____

____

____

<u>Important Information</u>

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:** ______________________________