Shepparton Travel Clinic
PO BOX 372, Numurkah VIC 3636 Email: olga@injectmedical.com.au www.sheppartontravelclinic.com.au

New Patient Information Form

*** FIRST NAME:**	***MS *MISS *MRS * MR *DR**
*** SURNAME**	
*** DATE OF BIRTH**	**SEX- Male/Female/Other**
*** RESIDENTIAL ADDRESS**	***SUBURB** ***POSTCODE**
*** POSTAL ADDRESS**	***SUBURB** ***POSTCODE**
*** HOME PHONE** **WORK PHONE**	**MOBILE**
*** MEDICARE NUMBER**	**Ref No.** **Expiry Date**
***DVA Gold / White** *(Please Circle)*	**Expiry Date**
*** CONCESSION CARD (Pension/HCC/Seniors HCC)**	**Ref No.** **Expiry Date**
EMAIL	
OCCUPATION	

EMERGENCY CONTACT

Contact One	Contact two
* NAME	* NAME
* RELATIONSHIP TO PATIENT	* RELATIONSHIP TO PATIENT
* ADDRESS	* ADDRESS
* PHONE NUMBER (H) (M)	* PHONE NUMBER (H) (M)

Is it possible you are pregnant or are you planning to become pregnant? **Yes** **No**

Do you have any allergies including medications, eggs, vaccines, other ?

☐ NO
☐ YES please elaborate _____

Would you like a copy of the immunisations given at Shepparton Travel Clinic sent to your MEDIRECORDS app account?

☐ NO
☐ YES

If yes please download the MEDIRECORDS app onto your mobile only. See attached information sheet

Are you taking any medication now /recently– **YES / NO**

If YES circle what applies and please write medication name/dose

- injections
- puffers
- tablets – eg oral contraceptive pill, prednisolone
- blood thinners
- immunosuppressants- methotrexate, chemotherapy agents, prednisolone
- other: _____

What medical issues have you had in the past/currently? (circle which applies)

- Asthma, chronic lung disease
- Diabetes,
- Joint problems such as Rheumatoid Arthritis, Psoriasis
- Removal of Spleen
- Cancers – Lymphoma/Leukemia/Breast Cancer/Colon Cancer, other …….
- Epilepsy
- Depression, Anxiety, Bipolar, other mental health issues
- Heart Disease, Arrhythmias, Irregular heart beat
- Weakness of Immune System, Guillian Barre Syndrome, HIV/AIDS, Thymus Problem, Autoimmune Problems
- Blood Clotting disorders, deep vein thrombosis, pulmonary embolism
- Hepatitis A
- Other_____Please List_____

Have you missed any of the routine childhood /school vaccines? **Yes No**

Please list in order the countries/cities you will be visiting, including the duration of your visit:

Country/cities	Duration	Accommodation Type-(hotel, tent)

Date of Departure: _____ Date of return: _____

How did you hear about our practice _____

Patient / Guardian Signature _____ Date: _____

New Patient Information Form

Consent Form for Collection and Use of Health Information

As a patient of our medical practice we require you to provide us with your personal details and a full medical history, so that we may properly assess, diagnose, treat and be proactive in your health care needs.
We aim to protect the privacy and secure storage of your health information. You can request a copy of our privacy policy, which includes information about the collection, use and disclosure of your health information.
We require your consent to collect personal information about you and to use the information you provide in the following ways. Please read this consent form carefully, and sign where indicated below.

- Administrative purposes in running our medical practice.
- Billing purposes, including compliance with Medicare.
- Disclosure to others involved in your healthcare including treating doctors and specialists outside this medical practice. This may occur though referral to other doctors, or for medical tests and in the reports or results returned to us following referrals.
- Disclosure to other doctors in the practice, locums etc. attached to the practice for the purpose of patient care and teaching.
- For research and quality assurance activities to improve individual and community health care and practice management. Usually information that does not identify you is used but should information that will identify you be required you will be informed and given the opportunity to "opt out" of any involvement.
- To comply with any legislative or regulatory requirements e.g. notifiable diseases.
- For reminder letters/SMS which may be sent to you regarding your health care and management.

You can decline to have your health information used in all or some of the ways outlined above but it may influence our ability to manage your health care to provide the best outcome for you.

I have read the information above and understand the reasons why my information must be collected.	☐
I understand that I am not obliged to provide any information requested of me, but failure to do so may compromise the quality of health care and treatment given to me.	☐
I am aware of my rights to access the information collected about me, except in some circumstances where access may be legitimately withheld. I will be given an explanation in these circumstances.	☐
I understand that if my information is to be used for any other purpose other than set out above, my further consent will be obtained.	☐
I consent to the handling of my information by the practice for the purpose set out above, subject to any limitations on access or disclosure of which I notify this practice.	☐
OR I am unsure and would like to discuss this further with someone from the medical practice before I sign. A full copy of the Shepparton Travel Clinic's privacy policy is available on our website or found at reception.	☐

Patients Name: _____ Date: _____

Patients signature: _____

Past Vaccine/Disease	**Year**
Tetanus/diphtheria/pertussis	
Hep A	
Hep B	
Typhoid	
Japanese Encephalitis	
Rabies	
Yellow Fever	
Meningococcal	
MMR	
Flu	
VZV	
Polio	
Cholera	
BCG	
Q fever	