**IMPORTANT INFORMATION (PLEASE READ)**

**New patient approval process**

All new patient forms must be approved by management before an appointment can be made. Once the new patient form has been approved the patient will be notified via SMS. If the patient has not made an appointment within the month of being notified the new patient form will be discarded and you will have to redo the new patient approval process**.**

**Patient Code of Conduct**

Relationships are based on openness, trust and good communication which enables practitioners and staff to work in partnership with patients or clients of the ATSICHS Mackay community.

Good partnerships between a patient, client or community members and the ATSICHS staff will require high standards of personal conduct.

This involves:

1. Being courteous, respectful, compassionate and honest.
2. Respecting the right of the ATSICHS MKY staff to choose whether he or she participates in any treatment or advice.
3. Not using threatening or abusive language. It will NOT be tolerated, and you will be asked to leave respectively. If you refuse authorities will be contacted
4. Not to present with any weapons or dangerous items. It will NOT be tolerated, and you will be asked to leave respectively. If you refuse authorities will be contacted.

**Appointments**

When booking reception will ask what the appointment is in regard to, to ensure appropriate amount of appointment time is made.

Patients require an appointment if they require any of the following

* Repeat scripts
* Forms to be completed
* Certificates

**Transport**

* Atsichs Mackay will provide Transport to all medical appointments if the patient has access to no other forms of transport.
* Transport can not be used for non-medical reasons (eg to shops, meetings, school).
* Patients inform reception 24/hrs before their appointment that they require transport.

**“We are committed to providing our clients with the best care; to do this it is essential that your medical records are up to date and accurate”**

**NOTE: All applications will be forwarded to Management to assess**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Surname**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **First Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Other names known as:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| **Date of Birth**: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ | **Place of Birth**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | **Marital Status: (please circle)**  Single / Married / Defacto / Widowed |
| **Are you of Aboriginal or Torres Strait Islander Descent?**  Aboriginal  Torres Strait Islander South Sea Island Non Indigenous  Clan/ Tribal Group: | | | | |
| **Sex:**  Male  Female | | | **KNOWN ALLERGIES: (Please list below)**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **Have you had a Health check in the last 12 Months?**  **Yes**  **No** | | |
| **Are you registered for Close the Gap / CTG ? Yes No**  ( Ask your Health Worker / GP about it) | | |
| **Current Contact Details:**  Street Address: Suburb: Post Code:  Postal Address: Suburb: Post Code:  **Phone contacts: Home:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Mobile:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **\*\*\*Do you consent to receive appointment reminders on the mobile number listed above via SMS:**  (Please Circle) YES NO | | | | |
| **( Must be Provided) Next of Kin Details:**  Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Phone No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    **Emergency Contact Details: (*Must be different to your Next of Kin)***  Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Phone No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| **Do you consent to sharing clinical information to My Health Record?** **YES**  **NO** | | | | |
| **Medicare Number**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Expiry Date: \_\_\_\_\_/\_\_\_\_\_ Reference: | | **Pensioner Concession Card /Health Care Card/ Centrelink Card No**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Expiry Date: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ | | |
| **DVA Card Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Card No: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Expiry Date: **\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_** | | **PBS Safety Net No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Expiry date: **\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_** | | |
| **NDIS Status** Eligible  Registered  Not applicable | | **Preferred Prescription Format (tick one)**  Email ePrescription Printed ePrescription Token  Printed Prescription  SMS Prescription | | |

**Personal Details**

**Your Health History -** **Do you have or had a history of?**

Cancer  Asthma  Diabetes  Mental illness  Heart Disease

High Blood Pressure  Other

Provide Details

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Medications (Including over the counter medications, vitamins, supplements)**

|  |  |  |
| --- | --- | --- |
| Medication Name | Dose | Reason for Use |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Female Only Have you had any of the following in the last 2 Years?**

Pap Smear Yes No Not Sure

Mammogram Yes No Not Sure

**Have you had Surgery Recently? (If so please provide details.)**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social History Do you use any of the following? (List frequency where appropriate).**

Tobacco  No

Sometimes (Social Smoker)

Ex-Smoker

Yes, Number Per Day\_\_\_\_\_\_\_\_\_

Alcohol  No

Yes Amount \_\_\_\_\_\_Day / Week

Would you like information on our AODS (Alcohol and other Drugs) program? Yes / No

Would you like information on our Sexual Health Program? Yes / No

**Children’s Immunisations - If patient is a child are their immunisations up to date?**

Yes No

**Does your child have a current Immunisation Record Book?**   **Yes**    **No**

# Family History - Have any members of your family had?

Diabetes  Asthma  Cancer  Mental illness  Heart Disease

Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Details

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**Do You have any other health concerns that you wish to be addressed?**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you want information on any of the following services ATSICHS Mackay provides?**

Social Workers Counselling AODS Quit Smoking

Women’s Groups Men’s Groups Kid’s groups  Community Closet

**ATSICHS staff and members comply with strict confidentiality guidelines on Personal Health Information and Medical Record of our clients.**

**However, your personal health information and medical record may be collected, used and disclosed for the following reasons:**

* For communicating relevant information with other treating doctors, specialists or allied health professionals
* For follow up reminder / recall notices
* For National / State or territory registers (e.g. Immunisation data)
* For State/Territory reminder systems, (e.g. Cervical screening- pap smear register or family cancer registries)
* Accounting/Medicare/ Health Insurance procedures
* Quality assurance procedures
* For disease notification as required by law (e.g. infectious diseases)
* For use by all doctors in this health service when consulting with you
* For legal related disclosure as required by a court of law (E.g. subpoena, court order, suspected child abuse)
* For research purposes (de-identified, meaning that your name is not listed in the information given)

If you have any concerns or wish to restrict access to your personal health information please discuss this with the GP or Receptionist.

**ATSICHS Mackay Ltd adheres to principles of the RACGP Handbook for the Management of Health Information in Private Medical Practice and has a written policy, which is available to all patients for inspection.**

**Reminder Systems:** Our recall system is a follow up process whereby clients are contacted to return to our Clinic generally to receive the results of ordered tests or/to receive follow up treatment. Our recall system is considered an essential component of quality care and also offers an active risk management approach.

**Consent**

* I provide my consent for Atsichs Mackay to collect and share my personal health information as stated above
* I provide consent for messages regarding my appointment to be left with my immediate family member / defacto partner.
* I have read and understood the important information provided above.

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

**Relationship:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Parent/Guardian to sign if client is under 16)