CAPALABA GENERAL PRACTICE

5 Larbonya Crescent, Capalaba Q 4157
Phone: 3245 3011 Fax: 3245 3022 Email: reception@capalabagp.com.au

SURNAME: Mr/Mrs/Miss/Ms ....

FIRST NAME: ....D.O.B: ....

ADDRESS: ....

HOME PHONE: ....WORK: ....MOBILE: ....

DO YOU CONSENT TO SMS APPT REMINDERS TO THIS MOBILE: YES □ NO □

EMAIL ADDRESS: ....

MEDICARE No: ....Exp Date: ....Reference No: ....

PENSION/HCC: ....Exp Date: ....

VETERANS AFFAIRS: ....Exp Date: ....

EMERGENCY CONTACT:

NAME: ....PHONE No: ....

***DO YOU IDENTIFY AS*:_ (Please √ Relevant Box)**

□ ABORIGINAL □ TORRES STRAIT ISLANDER □ ABORIGINAL/TORRES STRAIT ISLANDER
□ AUSTRALIAN □ NON - INDIGENOUS □ OTHER

DO YOU HAVE ANY CULTURAL OR RELIGIOUS BELIEFS THAT MIGHT BE RELEVANT TO YOUR ONGOING MEDICAL CARE? YES □ NO □

Dependants living at home who may attend this practice:

NAME	D.O.B.	RELATIONSHIP	MEDICARE NUMBER

I wish to consult at Capalaba General Practice.
I understand that I will be required to pay for all services for which a charge is applicable at the time they are provided.

Signed .... Date............/.........../..................

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CONSENT FORM FOR COLLECTION AND USE OF PERSONAL INFORMATION

Capalaba General Practice has produced a Privacy Policy that outlines the way we collect and use your information and how you can access that information.

This consent form covers collection and use of your information to provide comprehensive, co-ordinated and continuing whole person medical care. As outlined in the Privacy Policy, your information may be disclosed to other health care professionals to provide this level of care.

Separate, specific consent is required if your information is used for research, statistical or quality assurance purposed, or if the practice changes ownership and the services offered are significantly different from those provided by Capalaba General Practice.

By signing this consent form you acknowledge that you have read the Privacy Policy and you agree to your information being collected and used as described in the Privacy Policy.

If you have any questions in relation to this consent form of our Privacy Policy, please ask our staff or the Doctors.

I have read and understood the Privacy Policy provided by Capalaba General Practice and I consent to the collection and use of my information as described in the Privacy Policy:

Signature of patient/person responsible*:________________________________

Print Full Name:____

Date:____

*A 'person responsible' means a person defined as a 'person responsible' under the Privacy Act 1988 including the patient's partner, family member, care, guardian, close friend, and a person exercising power under an enduring power of attorney.

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Consent Form for Clinical Photography at Capalaba General Practice

Photographs are often routinely taken by the doctors at this practice who treat skin cancer, by the practice melanographer or by other staff under supervision, to form a part of your medical record. This may include photos of moles, other skin or medical conditions or surgical procedures. Photographs from medical records may be very helpful for other medical purposes, so we seek your consent to possibly use the photographs in your medical record for the following purposes.

- Getting an opinion from other expert doctors (at no cost to you).
- Educating other health professionals and medical students (Dr Rosendahl is an Associate Professor at the University of Queensland), other patients and in presentations to community groups. This includes use on medical web-sites, posters and brochures.
- Medical research and publication. (Dr Rosendahl is involved in research to improve the diagnosis and treatment of skin cancers and publishes the results of this research in medical journals, text books and educational posters). This research may include sending images to doctors who are researchers in international locations, most commonly at the Medical University of Vienna, Austria.

Doctors undertake that if any photographs from your medical record are used, they will be presented in such a way that you are not identified. If it is reasonably foreseeable that you may be identified from a photograph, we will not publish it without your further specific consent. You can withdraw your consent at any time but you should be aware that photographs cannot be withdrawn once they have been published.

I have read the information on this page and ***I consent to photographs from my medical record*** (including any already taken) ***being used for the purposes listed above including for teaching and medical research.***

Signed,

Please print your name

Date

Patient Medical History Questionnaire

Name: ________________________________ **Date of Birth:** _________________

Are you allergic to any medication?

☐ No

☐ Yes, Please specify below

____

____

Are you taking any regular medication?

☐ No

☐ Yes, Please specify below

____

____

Has any first-degree relative had skin cancers or melanomas?

☐ No

☐ Yes, Please specify below

____

____

Do you have any significant health issues?

☐ No

☐ Yes, Please specify below

____

____

Have you had any operations?

☐ No

☐ Yes, Please specify below

____

____

Is there anything else you want to tell us about your medical history?

☐ No

☐ Yes, Please specify below

____

____

Who is your usual General Practitioner?

____

____