NORFOLK ISLAND HEALTH & RESIDENTIAL AGED CARE SERVICES

New Patient / Health History Update Form

PLEASE NOTE ALL 3 PAGES MUST BE FILLED IN!

MR/MRS/MS/MISS/MASTER DRIVER LICENCE NUMBER: _____

NAME:_____ MIDDLE NAME:_____SURNAME: _____

KNOWN AS: _____ DOB:_____ MALE / FEMALE (Please Circle)

MEDICARE NUMBER:_____LINE NUMBER: _____EXPIRY: _____

HCC/PENSION/DVA/COMMONWEALTH SENOIRS (Please Circle) CARD NUMBER: _____EXPIRY: _____

IF DVA, WHAT COLOUR IS YOUR CARD ☐ GOLD ☐ ORANGE ☐ WHITE

DO YOU HAVE PRIVATE HEALTH INSURANCE? ☐ YES ☐ NO

IF YES, TYPE OF COVER_____ FUND NAME:_____ FUND NUMBER:_____

IF YOU ARE NOT IN A PRIVATE HEALTH FUND, DO YOU CHOOSE TO BE A SELF-FUNDED PRIVATE PATIENT? ☐ YES ☐ NO

RESIDENTIAL STATUS: (Please Circle)

Norfolk Islander/Resident Temporary Visitor/Tourist Hotel Name:_____

Do you identify as (Please tick): ABORIGINAL ☐ TORRES STRAIGHT ISLANDER ☐ NON-INDIGENOUS ☐

ADDRESS: _____PO BOX:_____

SUBURB: _____STATE: _____POSTCODE: _____

TELEPHONE: (H) _____ (W) _____ (M) _____

MARITAL STATUS: _____ OCCUPATION: _____

COUNTRY OF BIRTH: _____ ETHNICITY: _____

MAIN LANGUAGE SPOKEN AT HOME: _____ INTERPRETER REQUIRED ☐ YES ☐ NO

EMAIL: _____

HEIGHT: _____CM WEIGHT: _____KG WAIST CIRCUMFERENCE:_____CM (PLEASE ASK NURSE IF UNSURE)

ALLERGIES (PLEASE TICK): NO ☐ YES ☐ PLEASE SPECIFY: _____

SMOKING HISTORY: (PLEASE CIRCLE) SMOKER EX-SMOKER NEVER SMOKED

CIGARETTES PER DAY _____ YEAR COMMENCED _____ YEAR QUIT _____

HOW OFTEN DO YOU HAVE A DRINK CONTAINING ALCOHOL: (PLEASE CIRCLE)

NEVER / MONTHLY OR LESS / 2-4 TIMES MONTH / 2-3 TIMES A WEEK / 4 OR MORE TIMES A WEEK

ON THAT OCCASION HOW MANY STANDARD DRINKS CONTAINING ALCOHOL DO YOU HAVE: (PLEASE CIRCLE)

1 OR 2 / 3 OR 4 / 5 OR 6 / 7 TO 9 / 10 OR MORE

HOW OFTEN DO YOU HAVE SIX OR MORE DRINKS CONTAINING ALCHOL ON ONE OCCASION? (PLEASE CIRCLE)

NEVER / LESS THAN MONTHLY / MONTHLY / WEEKLY / DAILY OR ALMOST DAILY

ARE YOU COVERED BY WORKERS COMPENSATION: ☐ YES ☐ NO

ARE YOU COVERED BY THIRD PARTY: ☐ YES ☐ NO

ARE YOU AN OVERSEAS VISITOR: ☐ YES ☐ NO

SOLICITOR / EMPLOYER'S NAME:_____

ADDRESS:_____

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DO YOU SUFFER FROM ANY OF THE FOLLOWING?

	Yes	Year Diagnosed	No		Yes	Year Diagnosed	No
Coronary Heart Disease				Epilepsy			
Stroke				Arthritis			
Lung Cancer				Osteoporosis			
Breast Cancer				Oral Disease			
Any other Cancer				Asthma			
Type 2 Diabetes				Depression & Anxiety			
Chronic Kidney Disease				Chronic Obstructive Pulmonary Disease (COPD)			
High Blood Pressure				Type 1 Diabetes			

PLEASE NOTE ANY FROM THE PREVIOUS LIST THAT ANY OF YOUR IMMEDIATE FAMILY MEMBERS SUFFER FROM. INCLUDING: ***THEIR RELATIONSHIP TO YOU AND AGE AT DIAGNOSIS***. (EG. MOTHER, ARTHRITIS, 72) **IF DECEASED AGE AT DEATH.**

_____

_____

DO YOU HAVE ANY OTHER SIGNIFICANT MEDICAL CONDITIONS? IF SO, PLEASE LIST BELOW WITH YEAR OF DIAGNOSIS?

_____

_____

HAVE YOU HAD ANY MAJOR SURGERY OR OPERATIONS? IF SO, PLEASE STATE WHAT AND WHEN?

_____

_____

NUMBER OF CHILDREN: _____

SOCIAL HISTORY HOW MANY PEOPLE LIVE WITHIN YOUR HOUSE HOLD: _____

DO YOU LIVE WITH: (PLEASE CIRCLE) PARENTS / PARTNER / CHILDREN / FRIENDS / BY YOURSELF / OTHER

HOW MANY BROTHERS AND SISTERS DO YOU HAVE: BROTHERS _____ SISTERS _____

AUTHORISED CONTACT PERSON (**IF APPLICABLE**)

I authorise the following person/s to act on my behalf in regards to access to my records, results and other information that may be held by the clinic. I understand I can revoke this authority at any time by contacting the clinic in writing.

Contact Person 1:_____ Relationship to you:_____

Phone:_____Mobile:_____

Contact Person 2:_____ Relationship to you:_____

Phone:_____ Mobile:_____

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EMERGENCY CONTACT DETAILS	NEXT OF KIN CONTACT DETAILS
NAME:	**NAME:**
RELATION:	**RELATION:**
PHONE NUMBER:	**PHONE NUMBER:**

Privacy Statement

The Norfolk Island Health & Residential Aged Care Services (NIHRACS) – GP Clinic collects personal information, including sensitive information about clients, staff and contractors before and during the course of an individual's request for services from our facility. This may be in writing, in electronic form or in the course of conversations.

The primary purpose of collecting this information is to enable the organisation to provide our services to the individual and to enable the organisation to provide them with referral to other services that would be of benefit to them.

Some of the information we collect is to satisfy the organisation's legal obligations, particularly to enable the organisation to discharge its duty of care.

Laws governing or relating to the operation of a medical clinic require certain information to be collected and disclosed. These include relevant Health Records Acts, Health Act and other Public Health laws.

Health information about our clients, staff and contractors is sensitive information within the terms of the Australian Privacy Principles under the Privacy Act.

NIHRACS – GP Clinic from time to time discloses personal and sensitive information to others for administrative and health care related purposes including facilitating the receipt of additional services such as pathology, radiology, specialist opinions and services, other health organisations or providers, government departments such as Medicare or your health insurer.

Personal information collected from patients, staff member or contactor may seek access to personal information collected about them. However, there will be occasions when access is denied. For example, access would be denied where that access would have an unreasonable impact on the privacy of others, where access may result in a breach of the organisation's duty of care to the individual or where an individual has provided information in confidence.

NIHRACS – GP Clinic's Privacy Policy also sets out how you may complain about breach of privacy and how NIHRACS – GP Clinic will deal with such a complaint.

If you provide NIHRACS – GP Clinic with the personal information of others, such as doctors or emergency contacts or emergency contacts, we encourage you to inform them that you are disclosing that information to us and why. That they can access that information if they wish and that NIHRACS – GP Clinic does not usually disclose this information to third parties.

Please see the NIHRACS – GP Clinic Privacy Policy for more details – available at reception.

SIGNED……**DATE**……

PATIENT NAME/PARENT OR GUARDIAN NAME……