PATRICK MICHALKA
ORTHOPAEDIC & HAND SURGEON | MBBS FRACS(ORTH), FA ORTH

Personal Details:

Title: _____ Given Name/s: _____ Surname: _____

Date of Birth: _____Age:_____

Postal Address:

_____

Suburb: _____Postcode:_____

Contact Numbers: H _____W _____M_____

Email Address: _____ Occupation:_____

Medicare Number: __ __ __ __ __ __ __ __ __ __ Reference Number: _____

MUST BE 10 DIGITS BEFORE YOUR NAME

Guardian information for patients 16 and under

Medicare Number: __ __ __ __ __ __ __ __ __ __ Reference Number: _____ Date of Birth_____

MUST BE 10 DIGITS BEFORE YOUR NAME

Health Insurance Details:

Private Health Fund: _____ Membership Number: _____ Ref #: ____

Does your private insurance include hospital cover? Yes / No (please circle)

Do you have a pension card? If so what type:_____Card no:_____

Are you a DVA gold / white cardholder? Yes / No If yes, card number: _____

Referral Details

Referring Doctor: _____ Suburb/Clinic:_____

Family Doctor: _____ Suburb/Clinic: _____

Emergency Contact Details

Next of Kin: _____ Relationship: _____

Contact Numbers: H _____W _____ M _____

Hospital Admission

Have you been an in-patient or worked in a hospital / care facility in the last twelve months?

Yes/No (please circle) If yes, which hospital/care facility? _____

Is this appointment regarding a **workers' compensation** or **motor vehicle injury**?

Yes / No (please circle) *If yes* ***please complete page 3***.

PATIENT CONSENT TO USE, COLLECT & DISCLOSE INFORMATION

In accordance with the Privacy Act, this practice will ensure your privacy is protected.

Patient Name:_____

Our staff will use and disclose your personal information for purposes limited to:

- Referral to another health care provider
- Sending of specimens, such as blood sample, biopsies
- Referral to hospital for treatment
- Advice on treatment options
- To meet our obligations of notification to our medical defence providers
- Where legally required to do so, such as producing records to court
- Account keeping and billing processes

You will have access to your medical records except where it may not be prudent for this access to be given, such as:

- To provide access would create a serious threat to life or health
- There is legal impediment to access
- The access would unreasonably impact on the privacy of another
- The information relates to anticipated or actual legal proceeding and you would not be entitled to access the information in those proceedings

I consent to multimedia (photos/videos) being taken during procedures (please note: all arthroscopies will automatically have images taken) for the use of improving patient outcomes and training. If I request a copy of my multimedia there will be a nominal cost to me. Yes/No

How we will contact you

I understand that I can choose to have information by email/sms. This service is restricted to administrative purposes only to protect the privacy and confidentiality of patients as total security cannot be guaranteed. In providing and email address/mobile number, I acknowledge the risks and consent for my email.mobile number to be used for this purpose .

Please sign to acknowledge you have understood this form and that you consent to providing medical information to Mr Patrick Michalka.

Signed:_____**Name:**_____**Date:**_____

If under 16 Guardian to sign on behalf of patient:

Signed:_____**Name:**_____**Date:**_____

I consent to the information contained in this form being shared with the HAND AND UPPER LIMB CENTRE Yes/No (please circle)

Signature _____ **Date** _____

If your appointment is regarding a **workers' compensation/MVIT injury** please complete **the sections below:**

Workers' Compensation

Employer name:		
Employer postal address:		
Name of Employer's Insurance Company:	***Claim number:***	***Date of accident:***

MVIT

Insurance Company:		
Address:		
	Claim number:	***Date of accident:***

Please Note: If this is a new injury and you **do not know** the above details, please check with your employer and telephone your surgeon's rooms with this information as soon as possible. Failure to pass on this information or rejection of your claim by the insurance company will result in you being personally liable for any invoices raised in the course of your treatment.

Authority For Release of Information

I _____ (insert name) give permission for you to forward confidential information regarding my injury, the treatment I have received and guidelines for return to work to my employer, insurance company and rehabilitation provider.

This signature confirms I have read, understood and agree with the terms of the above statement.

Signature:	***Date:***