CTL MEDICAL

CTL MEDICAL & CAIRNS TRAVEL CLINIC
PO BOX 3066, CAIRNS QLD 4870 PHONE: (07) 40 411 699 FAX: (07) 40 411 682
EMAIL: CTLMED@CTLMEDICAL.COM.AU WEB: WWW.CTLMEDICAL.COM.AU
ABN 82 074 324 977

TITLE: DR MR MRS MS MISS MAST PROF SIR LADY FR (Please circle)

SURNAME: _____ **FIRST NAME:** _____ **MIDDLE NAME/S:** _____

KNOWN AS: _____ **DOB:** ____/____/____ **GENDER:** MALE / FEMALE / OTHER / UNKNOWN

TO ASSIST WITH HEALTH INITIATIVES: DO YOU IDENTIFY WITH ANY SPECIFIC CULTURAL BACKGROUNDS? (PLEASE CIRCLE BELOW)

ABORGINAL TORRES STRAIT ISLANDER NON-INDIGENOUS AUTRALIAN OTHER: _____

HOTEL OR PLACE OF RESIDENCE IN CAIRNS: _____

INSURANCE COMPANY & POLICY NUMBER: _____

RESIDENTIAL ADDRESS: _____

SUBURB: _____ POST CODE: _____ **COUNTRY OF BIRTH:** _____

CONTACT INFORMATION: HOME: _____ WORK: _____ MOBILE: _____

WE STRONGLY SUGGEST CONNECTION WITH OUR BEST PRACTICE COMMS MESSAGING SERVICE.

THIS ALLOWS DIRECT RESULTS & MEDICAL COMMUNICATIONS VIA SMS FROM THE DOCTOR? YES ☐ NO ☐

EMAIL: _____ **OCCUPATION:** _____

MEDICARE CARD NUMBER: _____ REFERENCE # _____ EXPIRY: ____/____

PENSION CARD NUMBER: _____ EXPIRY: ____/____ **DVA NUMBER:** _____

NEXT OF KIN: FIRST NAME: _____ LAST NAME: _____

RESIDENTIAL ADDRESS: _____

SUBURB: _____ POST CODE: _____ RELATIONSHIP: _____

MOBILE NUMBER: _____ EMAIL: _____

EMERGENCY CONTACT: FIRST NAME: _____ LAST NAME: _____

RESIDENTIAL ADDRESS: _____

SUBURB: _____ POST CODE: _____ RELATIONSHIP: _____

MOBILE NUMBER: _____ EMAIL: _____

DO YOU HAVE ANY KNOWN ALLERGIES OR ARE YOU SENSITIVE TO ANY SPECIFIC DRUGS OR DRESSINGS?

_____

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HEALTH INFORMATION COLLECTION AND USE CONSENT FORM

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. We require your consent to collect personal information about you and to use the information you provide in the following ways.

- Administrative purposes in running our medical practice
- Billing purposes, including compliance with Medicare commission requirements
- Disclosure to others involved in your healthcare including treating doctors and specialists outside of this medical practice. This may occur through referral to other doctors for medical assessments and in the reports or results returned to us following referrals.
- Disclosure to other doctors, locums etc. attached to the practice for the purpose of patient care
- 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 messages and/or emails which may be sent to you regarding your health care and management.

Please read this consent form carefully and sign where indicated below.

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 obligated 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 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	☐

Patients' name: _____ **Date:** _____

Patients' signature: _____