PDC Personal Details & Consent Form

PDC offers Diabetes and Allied Health services.

Please circle: MR MRS MS MASTER MISS DR OTHER (please specify):			
First Name:	**Last Name:**	**Preferred name:**	
Date of Birth:	**Gender:** **Pronouns:**	**Occupation:**	
Are you of Aboriginal and/ or Torres Strait Islander origin? (please circle) Aboriginal Torres Strait Islander	**Are you registered for Closing the Gap?** YES / NO / UNSURE	**Ethnicity:**	**Religion:**
Home phone:	**Mobile:**	**Email:**	
Address:		**Mailing Address (if different)**	
Emergency Contact Name: **Relationship to you:** **Contact number:**		**Do you have a disability?** YES / NO **If yes, please provide details:**	
Medicare number:		**IRN:**	**Expiry:**
Concession Card (please circle): Health care card Pension card DVA Other	**Concession Card Number:**		**Expiry:**
Do you have private health insurance? YES / NO **Member number:**		**Do you consent to text reminders?** YES / NO	
Do you have diabetes? YES / NO **Please specify what type of diabetes:**			**NDSS Number:**
Do you have any allergies? YES / NO **Product/Reaction/Severity:**		**Regular Pharmacy:**	
Regular medications: **(or provide list to reception)**		**Current medical conditions:** **(or provide list to reception)**	
Are your immunisations up to date? YES / NO		**Are you a smoker?** YES / NO **Quit date:**	
Regular GP Name:		**Do you see a specialist or Endocrinologist?** **If yes, please provide details:**	
FOR PATIENTS WITH DIABETES ONLY			
Current Blood Glucose meter/Continuous Glucose monitor:		**Current Insulin Pump: (if relevant)**	

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FOR PDC ALLIED HEALTH PATIENTS:

In order to thoroughly assess, diagnose and provide therapy, we need to collect some personal information. If you do not provide this information; we may be unable to provide the best possible treatment. This information will also be used for:

(a) The administrative purpose of running the practice;

(b) Billing either directly or through an insurer or compensation agency;

(c) Use within the practice if discussing or passing your case to another practitioner within the practice for your ongoing management;

(d) Disclosure of information to your doctors, other health professionals or to teachers to facilitate communication and best possible care for you; and

(e) In the case of insurance or compensation claim it may be necessary to disclose and/or collect information that concerns your return to work to an insurer or your employer

De-identified data may be used for research purposes and I consent to its use. We do not disclose your personal information to overseas recipients.

PDC Allied Health has a Privacy Policy that is available on request. The policy provides guidelines on the collection, use, disclosure and security of your information. The Privacy Policy contains information on how you may request access to, and correction of, your personal information and how you may complain about a breach of your privacy and how we will deal with such a complaint.

To ensure the process of quality treatment provision, information about your assessment results and progress may be given to relevant other service providers, who are involved in your management. These may include your doctor, teachers, specialists, insurers, solicitors or employers.

PDC Allied Health is committed to providing the best quality care and service to our patients. For all patients to be able to access our valuable services, a cancellation policy applies to all appointments.

If for any reason you are unable to attend your scheduled appointment, you must notify PDC Allied Health a minimum of 24 hours prior to your appointment time. You can do so by calling us on (08) 6110 0570. This ensures we can work with you to reschedule your appointment and open other times to patients who may be waiting for urgent appointments. Please be aware that if less than 24 hours' notice is provided or you miss your appointment, the cost of your scheduled session will be charged as a cancellation fee.

Signing below acknowledges that you have read and understood and accept the above terms and conditions for attending PDC Allied Health and/or PDC Medical.

Signature : _____ **Date:** _____