Heart of Canberra — New patient registration

DR KASHIF KALAM · MBBS, FRACP · CARDIOLOGIST

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Please complete before your first appointment and bring it with you, or email it to the rooms. Fields marked * are required. You will also need your referral letter and Medicare card on the day.

ABOUT YOU

FULL NAME (AS ON YOUR MEDICARE CARD) *

PREFERRED NAME

DATE OF BIRTH *

SEX

☐ Female ☐ Male ☐ Another term ☐ Prefer not to say

HOME ADDRESS *

MOBILE PHONE *

OTHER PHONE

EMAIL

PREFERRED WAY TO CONTACT YOU

☐ Phone ☐ SMS ☐ Email

DO YOU NEED AN INTERPRETER?

☐ No ☐ Yes

If yes, please tell us the language in the notes at the end.

DO YOU IDENTIFY AS ABORIGINAL AND/OR TORRES STRAIT ISLANDER?

☐ Prefer not to say ☐ No ☐ Aboriginal ☐ Torres Strait Islander ☐ Both

Optional. Asked so the practice can offer the right services.

MEDICARE AND CONCESSIONS

MEDICARE CARD NUMBER *

10 digits, on the front of the card.

YOUR NUMBER ON THE CARD *

The single digit beside your name.

MEDICARE CARD EXPIRY

DVA CARD

☐ None ☐ Gold ☐ White

DVA FILE NUMBER (IF YOU HOLD A CARD)

PENSION OR CONCESSION CARD NUMBER (IF ANY)

Pensioner fees apply — see Appointments and fees.

PRIVATE HEALTH FUND AND MEMBER NUMBER (OPTIONAL)

YOUR DOCTORS

REFERRING DOCTOR *

REFERRING DOCTOR'S PRACTICE *

YOUR USUAL GP, IF DIFFERENT

YOUR GP'S PRACTICE

EMERGENCY CONTACT

NAME *

RELATIONSHIP TO YOU

PHONE *

YOUR HEALTH

WHY HAS YOUR DOCTOR REFERRED YOU? (IN YOUR OWN WORDS)

CURRENT MEDICATIONS, INCLUDING DOSES

Or bring the boxes or a pharmacy printout.

ALLERGIES AND REACTIONS

Include contrast dye reactions if you have had one.

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

- ☐ Heart attack
- ☐ Stents or bypass surgery
- ☐ Atrial fibrillation or another rhythm problem
- ☐ Pacemaker or defibrillator
- ☐ Heart failure
- ☐ Heart valve problem
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Diabetes
- ☐ Kidney disease
- ☐ Stroke or TIA
- ☐ Sleep apnoea

HEART DISEASE IN A PARENT, BROTHER OR SISTER BEFORE AGE 60?

☐ No ☐ Yes ☐ Unsure

SMOKING

☐ Never ☐ Former ☐ Current

PREVIOUS HEART TESTS OR SCANS, AND WHERE (IF KNOWN)

CONSENT AND COMMUNICATION

MAY WE SEND APPOINTMENT REMINDERS BY SMS?

☐ Yes ☐ No

MAY WE SEND REPORTS TO YOUR GP AND REFERRING DOCTOR?

☐ Yes ☐ No

☐ I have read the practice privacy policy and understand my information is used to provide my care, shared with my referring doctor and GP, and used for Medicare and billing. * The privacy policy is at www.heartofcanberra.com.au/privacy-policy and available at the rooms.

ANYTHING ELSE THE ROOMS SHOULD KNOW (OPTIONAL)

SIGNATURE _____ DATE _____

Office use: referral received ☐ Medicare verified ☐ concession verified ☐ entered by _____ date _____

Heart of Canberra collects this information to provide your care and for Medicare and billing. It is handled under the Privacy Act 1988 and the practice's privacy policy, available from the rooms. This form is not for urgent problems — if you have severe or sudden chest pain, call 000.