



Please complete ALL pages and return
before your first appointment

www.harpneurology.com.au
Tel: 03 9851 6323

CONFIDENTIAL INFORMATION

PERSONAL DETAILS

Mr Mrs Miss Ms Master Dr Prof Other DOB: ___ / ___ / ____

Surname: **Given Name:**

Address:

Suburb: **Postcode:**

Email: **Occupation:**

Phone Numbers: Home: Work:

Mobile:

Next of Kin details: (family member or friend / medical power of attorney)

Name: Relationship to you:

Contact Number:

Person Responsible for fees: Self Parent State-trustee Other

REFERRAL AND PRACTITIONER

GP's Name: **GP Provider Number:**

Practice Details

Contact Number:

CLAIM DETAILS

Medicare Number: **Ref No:** **Exp date:**

Private Health Insurance: YES NO

Fund Name: **Fund No:**

Concession Cards

Aged or Disability Pension No: **Exp date:**

Dept. Veterans Affairs Card No: WHITE GOLD **Exp date:**

Health Care Card No: **Exp date:**



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MEDICAL HISTORY

Please list all current medication conditions: (if included in original referral and correct, there is no need to re-list)

- | | |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

Please list all current medications AND doses: (if included in original referral and correct, there is no need to re-list)

- | | |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

Please list all allergies:

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

Please list any previous surgeries

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

Have you ever had botulinum toxin (Botox or Dysport) therapy before? YES NO

If Yes, what was the date of your last treatment: ____ / ____ / ____



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Please list any other Doctors you are seeing:

Doctor 1

Name: Specialty:

Contact Number: Location:

Doctor 2

Name: Specialty:

Contact Number: Location:

Doctor 3

Name: Specialty:

Contact Number: Location:

MRI SAFETY CHECK

Please indicate if you have:

- | | | |
|---|------------------------------|-----------------------------|
| 1 . Done any welding, grinding or sheet metal work | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 2 . A cardiac pacemaker or defibrillator | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 3 . A bionic ear / cochlear implant | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 4 . A brain / cerebral aneurysm clip | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 5 . Any metallic surgical implant or foreign bodies | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 6 . A spinal cord or deep brain stimulation device | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 7 . Peripheral nerve stimulation device | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 8 . History of metal fragments in the eye, head or body | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 9 . Shrapnel or gunshot wounds | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 10 . Shunt (spinal or ventricular) | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 11. Claustrophobia | <input type="checkbox"/> YES | <input type="checkbox"/> NO |



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PRIVACY

All information collected by this practice will be used for providing healthcare. Collection, utilisation and storage of this information will be compliant with the 2001 Health Records Act.

COMMUNICATION

What type of appointment would you prefer:

In-person Video-conference Telephone

Are you happy to receive appointment related information via email: YES NO

Are you happy to receive appointment reminders via SMS: YES NO

CONSENT

Please sign to confirm that the information provided is accurate and you consent to Harp Neurology collecting my health information:

Signature:

Date:

Name (please print):