## Patient Information Form

Title: (Please circle applicable) Mr / Mrs / Ms /	Dr Last Name:		
First Name:	Date of Birth:	//	
Address:			
Suburb:	State:	Postcode:	
Phone:	Mobile:		
Email:			
Medicare No	Ref No Expiry		
Private Health Fund	Member Number		
Pension Number	Expiry		
Health Care Card No	Expiry		
DVA Card No	Expiry		
Driving by / Facebook / Friend or Family / GP or Referring Doctor	General Practitioner (leave blank if	same as Referring Doctor)	
Name			
Clinic			
AddressPhone			
If treatment is for a Workers Compen			
Employer Name (who pays your wages?):			
Employer Address: Name of Insurer:	Date of Injury:	Claim Number:	
	Date of injury:		
Emergency Contact Person			
Name	Relationship:	Relationship:	
Mobile Ph:	Work/ Home:		
Patient Privacy Consent Form Endovascular WA and our staff are committed t You have been referred to our practice for a me injection(s) and we collect information from you We do require you to consent to the collection,	dical consultation, radiological examinate that is necessary to provide you with he	tion, medical procedure(s) or ealth care services.	
We may use your information amongst health p	• •		

Endovascular WA and our staff are committed to ensuring the privacy and confidentiality of your personal information. You have been referred to our practice for a medical consultation, radiological examination, medical procedure(s) or injection(s) and we collect information from you that is necessary to provide you with health care services. We do require you to consent to the collection, use and disclosure of your personal health information. We may use your information amongst health professionals to provide your treatment including however not limited to your referring doctor, your general practitioner and any other health service provider in the treatment of your health care. At Endovascular WA we may need to use our medical typist who is located offshore and for reporting purposes they may require access to your information. You have the right to have access to the health information that we hold in your health record. All further clarification and information can be found in the Australian government privacy act of 1988. Please ask one of our friendly receptionists for a copy of this should you require it.

## **Record of Consent**

I consent to the collection, use and disclosure of my personal health information at Endovascular WA. I agree to the information from any radiological studies, medical consultation and treatment performed at Endovascular WA to be collected, used and disclosed to the health provider(s) to whom I am referred to assist in the management of my healthcare. I understand that I may withdraw my consent at any time.

Patients Full Name Patients Signature Date

