LIMB RECONSTRUCTION CENTRE

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PATIENT DETAILS:

Surname: ____ Title: ____________________

First Name: ____________________________ Middle Name: ____________________________

Date of Birth: ____

Address: ____

Telephone: Home: _____________________________ Work: ____________________________

Mobile _______________ □ I consent to receive appointment reminders and recalls sent via SMS.

Email: ____

Occupation: ____

Parent's details if patient under 18 years old:

Name: ___________________________ DOB: _______________ No on Medicare Card: ______

MEDICARE, HEALTH INSURANCE ETC:

Medicare No: _______/_________/________Expiry: _______/_______ No. on card: ________

Private Health Fund - Name of Fund: _____________________ Member No: ________________

□ **NO** Private Health Insurance (Self-funded / No Rebate)

□ **Pensioner:** *Please specify*___________________________ Expiry: _______/_______

□ **DVA**: No________________ Card colour: _________________

EMERGENCY CONTACT DETAILS:

Name: ____

Telephone: Home: _______________ Work: _______________ Mobile: ____________________

Relationship: ____

TREATMENT AREA /PRESENTING PROBLEM:

☑ Please Tick -
□ **Left** □ **Right** □ **Both**

□ Hip □ Knee □ Foot □ Ankle □ Shoulder □ Elbow □ Hand/Wrist

□ Amputee (Above knee / Below knee)

GENERAL PRACTITIONER:

These details allow us to keep your family doctor informed of your treatment.

Name: ____

Address: ____ Phone: _______________

□ I do not have a family doctor/General Practitioner

PHYSIOTHERAPIST:

Name/Clinic: ____

HOW DID YOU HEAR ABOUT US? (PLEASE TICK ONE):

□ GP □ Physiotherapist □ Specialist □ Friend/Family

Other (Please specify): ____

ARE YOU MAKING A CLAIM FOR COMPENSATION? ☑ Please Tick □ **NO**

□ Workers' Compensation □ CTP □ Personal Injury Claim □ Public Liability

Claim Number: _____________________________ Date of Injury: ___________________

Case Manager: ________________________ Ph: _____________ Fax: _____________

Email: ____

Insurance Company: ____

Address: ____

Employers Name: ___________________________ Telephone: ____________________

If the compensation insurer refuse to approve this claim or pay any accounts in relation to my treatment then I agree to pay all accounts.

Name: ______________________ Sign: ______________________ Date: ____________

Weight: ______________________________ **Height:** ______________________________

Age: ________________________________ **Marital Status:** _______________________

Do you have or have ever had the following conditions? Please answer every question with a tick yes or no, and a circle where appropriate.

	Yes	**No**		**Yes**	**No**
High Blood Pressure			Kidney problems		
Elevated Cholesterol/triglycerides			Hepatitis		
Pacemaker, other cardiovascular issues please specify:			Varicose Veins		
Chronic regional pain syndrome			Deep Venous Thrombosis		
Diabetes controlled by: Diet Tablets Insulin			Do you take aspirin, blood thinning medication or anti-inflammatories?		
Asthma			Depression, PTSD or other:		
Emphysema, shortness of breath or other lung problems			Neck or back injuries/problems		
Sleep apnoea (CPAP)			Do you smoke? /per day Have you ever smoked?		
Stroke (CVA)			Do you drink alcohol? /per day		
Epilepsy, fits, faints or funny turns			Problems with anaesthetics, e.g. vomiting		
Stomach problems, gastric ulcer, indigestion or reflux			Do you have any wound or skin breaks? MRSA?		
Cancer			Other, please specify:		

If you answered **yes** above, provide further details on any condition requiring further explanation.

____

____

Other specialists involved in your care? ______________________________

____

____

Previous surgery, including dates if possible: ___________________________

____

____

Current medications, including herbal preparations: _____________________

____

____

Allergies to medications, metals or other: ______________________________

____

____

DECLARATION

I herby certify that the medical information I have provided above is true and accurate to the best of my ability.

I give permission for The Limb Reconstruction Centre including all medical professionals and staff to collect and store my information (medical history, personal details including address, telephone number, Medicare number or current mediations). I understand all staff will have access to this information. I also give permission for correspondence to be sent to my referring doctor, treating doctors, General Practitioner, Physiotherapist, Insurance Company or any other relevant specialist where appropriate.

I undertake to pay all fees owing to The Limb Reconstruction Centre or my Surgeon, including in the event that liability is denied or any outstanding accounts that have not been paid in full by my insurer.

I also understand that any outstanding monies requiring debt recovery will incur Debt Recovery fees and I will also be responsible for any legal costs incurred.

Signed by patient or parent/guardian: __________________________ Date: ___________________