WELCOME TO KAMBU HEALTH

It is essential that your health record contains complete and accurate information to provide you with quality care. Please assist us by filling out the new patient record form below. Your personal health information is kept private and secure as required by federal and state privacy laws.

PERSONAL DETAILS

Title	Given Name(s)	Middle Name
Surname		
Preferred Name (if different to above)		
Date of Birth / /	Gender ☐ Male ☐ Female ☐ Other	
Accommodation (please tick)	☐ Private Residence ☐ Private Rental ☐ Public Rental ☐ Group Home ☐ Homeless ☐ High Care Residential Facility ☐ Low Care Residential Facility ☐ Retirement Village	
Address		
Suburb	Occupation	
Place of Work/School		
Mobile Phone	Home Phone	
Email		

CARE STATUS

Is this person under 18yrs? (If Yes please complete below) Your answers assist the GPs to provide the best protection to the child.	No / Yes
Are you this child's legal guardian?	No / Yes
Is this child under the protection of Department of Child Safety?	No / Yes
Do you have an Authority to Care?	No / Yes
Are there any court orders in place for this child?	No / Yes

HEALTH COVER

Medicare Number ☐☐☐☐☐☐☐☐☐☐	Ref	Expiry / /
Concession Card CRN ☐☐☐☐☐☐☐☐☐☐	Start / /	Expiry / /
Card Type ☐ Health Care Card ☐ Aged ☐ Disability ☐ Carer ☐ Service ☐ Parent Pension Support ☐ Seniors Health Card ☐ Veterans Affairs Card		
NDIS Participant: Number:	Plan Start Date: / /	Plan End Date: / /
DVA Number	Card Type ☐ Gold ☐ White	
Private Health Number	Fund Name	

NEXT OF KIN

Next of Kin Name	Relationship
Phone Number	
Emergency Contact Name (If different to above)	Relationship
Phone Number	

BACKGROUND

Do you Identify as Aboriginal and/or Torres Strait Islander?

☐ No ☐ Yes - Aboriginal ☐ Yes - Torres Strait Islander ☐ Yes - Aboriginal and Torres Strait Islander

You may be asked to provide proof or confirmation of Aboriginal and/or Torres Strait Islander heritage.

Do you speak any other languages other than English? ☐ No ☐ Yes

Do you need an Interpreter? ☐ No ☐ Yes (please provide details: Language: .....)

Have you had a chronic illness for 6 months or longer? ☐ No ☐ Yes (please describe: .....)

.....)

Do you have any known allergies? ☐ No ☐ Yes (please describe: .....)

.....)

Are you currently taking any medication? ☐ No ☐ Yes (please describe: .....)

.....)

CONSENT

Kambu Health Clinic collects information from you for the primary purpose of providing quality health care. Your personal information will only be used for the purpose for which it was collected or as otherwise permitted by law, and we respect your right to determine how your information is used or disclosed.

We require your consent to collect personal information about you and to use the information you provide in the following ways:

- Administrative purposes in running our medical practice.
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
- Disclosure to others involved in your healthcare including treating doctors and specialists outside this medical practice. This may occur though referral to other doctors, or for medical tests and in the reports or results returned to us following referrals.
- Disclosure to other doctors in the practice, locums etc. attached to the practice for the purpose of patient care and teaching.
- For research and quality assurance activities to improve individual and community health care and practice management. Usually information that does not identify you is used but, should information that will identify you be required, you will be informed and given the opportunity to "opt out" of any involvement.
- To comply with any legislative or regulatory requirements e.g. notifiable diseases.
- For reminder letters which may be sent to you regarding your health care and management.
- Access to Closing the Gap (CTG) Pharmaceutical Benefits Scheme (PBS) Co-payment reducing the cost of PBS medicines

Please read this consent form carefully, and sign where indicated below.

You can decline to have your health information used in all or some of the ways outlined above but it may influence our ability to manage your health care to provide the best outcome for you.

☐ I have read the information above and understand the reasons why my information must be collected.

☐ I understand that I am not obliged to provide any information requested of me, but failure to do so may compromise the quality of health care and treatment given to me.

☐ I am aware of my rights to access the information collected about me, except in some circumstances where access may be legitimately withheld. I will be given an explanation in these circumstances.

☐ I understand that if my information is to be used for any other purpose other than set out above, my further consent will be obtained.

☐ I consent to the handling of my information by the practice for the purpose set out above, subject to any limitations on access or disclosure of which I notify this practice.

☐ Yes, I would like Kambu Health to contact me regarding events, community newsletters, experiences, competitions, promotions, surveys, and other awesome opportunities.

OR

☐ I am unsure and would like to discuss this further with someone from the medical practice before I sign.

Signature of Patient or Guardian: ..... Date: / /

Please advise us if your contact information or Medicare details change.

REQUEST FOR ACCESS TO MEDICAL RECORDS

www.kambuhealth.com.au

Transfer of Health Information: You may have consistently consulted with a GP at another practice. The health information held by that GP may assist us with your future health care needs. You can request to have a summary of your health records transferred to this practice. Please complete the below form so our receptionist can request your previous records.

Previous practice: .....

Address: .....

Contact details: .....

Name: ..... Date of Birth: ..... / ..... / .....

Address: .....

I, hereby consent to the release of clinical information to the above named health care professional who is currently directly involved in my ongoing care.

Patient Signature: .....

As the above patient is now attending this surgery and has requested we obtain a copy of their medical records, would you please forward these copies at your earliest convenience?

Information Required	Date Performed	Please Tick if Not Performed
GP Management Plan - 721		
Team Care Arrangement - 723		
Mental Health Care Plan - 2715/2717		
Health Assessment - 715		
Full Medical History		
Discharge Summary		
Procedures		
Results		
Letters		
Relating to		

Ipswich Clinic

27 Roderick Street
IPSWICH QLD 4305

ipswichclinic@kambuhealth.com.au

(07) 3810 3000

(07) 3812 5177

Laidley Clinic

164 Patrick Street,
LAIDLEY QLD 4341

laidleyclinic@kambuhealth.com.au

(07) 5465 3541

(07) 5465 3156