Aboriginal Health Services Client Registration and Consent Form

HealthWISE
NEW ENGLAND NORTH WEST

Is the Client either Aboriginal, Torres Strait Islander or Both? Yes ☐ No ☐

Surname: _____ **First Name/s:** _____

Known as any other name: _____

Address: _____

Town: _____ **Post Code:** _____

Home: _____ **Work:** _____ **Mobile Phone:** _____

Date of Birth: ____/____/_____ **Current Age:** _____ *(If patient is under the age of 16, Parent/Guardian permission must be given)*

Usual Practice: _____ **Preferred Doctor:** _____

Alternate / Emergency Contact – Name: _____ **Phone:** _____

1. This form registers an individual(s) to become a member client of HealthWISE New England North West Health Access Services.
2. Registration will entitle the member client to access services within the HealthWISE New England North West Health guidelines which can include but are not limited to:
   - assistance to access health services;
   - assistance with transport to health related appointments;
   - assistance to access specialist appointments/treatment;
   - information and assistance to access available health programs etc.
3. All information shared between the member client and HealthWISE New England North West Health will be treated as strictly confidential at all times.

At any stage the member client can request to be removed from the service.

I, *(or my child/ward)* _____
(Patients Full Name)

hereby agree to my *(or my child/ward's)* records being kept in the computer database of HealthWISE New England North West Health. I acknowledge that the purpose of the database is to assist in the management of health checks and possible health condition/s and to establish health outcome goals in the community.

I understand that all results relating to my *(or my child/ward's)* health checks and/or health condition/s may be accessible to Health Service providers involved in my *(or my child/ward's)* care.

This consent is subject to:

1. The information on the database being kept strictly confidential;
2. Any information required for research being used on de-identified data reports;
3. My right to withdraw consent at any time by completing a withdrawal form requesting my file be destroyed.
4. My Medical History and diagnosis being discussed with my GP and other health professionals involved in my care.

Patient Signature: _____ _____ **Date:** _____/_____/_____

Parent/Guardian Name: _____ _____

Parent/Guardian Signature: _____ _____ **Date:** _____/_____/_____

For Office Use Only

Date Entered:	***Staff member:***

Client Intake Form
Aboriginal Health Services

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Client Information

Are you Registered on PBS Co-Payment (CTG Scripts): Yes or No

MBS Item 715 Completed: Yes or No

If no for either or both of these questions discuss with the client how these initiatives may assist their Health Outcomes.

Height: _____ **Weight:** _____

Smoker: Non Smoker ☐ Yes ☐ Current ☐ Ex ☐

Drinker: Non Drinker ☐ Yes ☐ If yes, how many Alcoholic drinks per week: _____

Chronic Condition: Yes or No

Diabetes Type II ☐ CVD ☐ COPD ☐ Other: _____

Immunisation: Yes or No Influenza: ☐ Month/Year Last Immunised: _____

(For Clients 50 years of age and older)

For children 5yrs and Under Refer to Child's Blue Book:

Immunisation Update C-5 Schedule

Birth	☐	Date: _____	*(HB Vax II)*
6-8 Weeks	☐	Date: _____	*(Rotarix, Intanrix hexa, Prevenar 13)*
4 Months	☐	Date: _____	*(Rotarix, Intanrix hexa, Prevenar 13)*
12 Months	☐	Date: _____	*(Mentorix, MMRII/ PRIORIX)*
18 Months	☐	Date: _____	(*Priorix-textra)*
3.5 - 4 Years	☐	Date: _____	(*Infanrix IPV, MMRII/PRIORIX)*

Pregnancy: Yes or No If yes, how many weeks are you: ____ weeks

When did you first present to the Doctor? _____

If you don't have the answers at the time of completing this form. A staff member of HealthWISE New England North West will contact you or your Health Provider for these details.