Dr Harry Singh
Dr Kate Riney
Dr Yeeshu Singh
Dr Harini Sundaravadanam
Dr Jeff Fletcher
Dr Carolyn Ng
Dr Kai Ismail

Phone: 0755 394 961 Fax: 07 55 278 438
5/39 White Street, Southport Qld 4215
Email: admin@qldpaeds.com.au

Patient Information/Consent Form

PATIENT DETAILS

Surname:______________________________________ Given Name:____________________________

Street No/Name:____ Sex: M / F / Other

Suburb :____Post code:________________

Date of Birth: _____/______/______ School / Daycare: ____

Medicare Number: ________________________________ Ref No: ________ Expiry Date: ____________

Private Health Insurance YES / NO Private Health Fund Name: _________________________________

Patient Member Number: __________________ Patient Ref No: ___________ Expiry Date: ____________

PARENT/GUARDIAN - ACCOUNT HOLDER DETAILS *(for Medicare purposes)*

Surname:___________________________ Given Name:____________________ DOB: ____/___/____

Relationship to Patient: ________________________ Is your address the same as the patient? YES / NO

Contact Numbers - Mobile : ____________________ (H)_________________ (W)____________________

Medicare Number: ________________________________ Ref No: ________ Expiry Date: ____________

Email: ____ *(Mandatory – not for advertising purposes)*

PARENT/GUARDIAN

Surname:___________________________ Given Name:_____________________ DOB: ____/___/____

Relationship to Patient: ________________________ Is your address the same as the patient? YES / NO

Contact Numbers - Mobile : _____________________ (H)_________________ (W)____________________

Medicare Number: ________________________________ Ref No: ________ Expiry Date: ____________

Email: ____ *(Mandatory – not for advertising purposes)*

Do you consent to be contacted via SMS *(text message)* for appointment reminders or other messages from Queensland Paediatric Specialists? **YES / NO**

Are there any current Custody Arrangements or Court Orders in place for this child? YES / NO

(If you answered yes, please discuss this in more detail with your doctor during your first consultation)

Referring Dr Name: ___________________________ Clinic/Suburb: ________________________________

Patients GP Name: ___________________________ Clinic/Suburb: ________________________________

REFERRALS

Please note that it is your responsibility to ensure that your child has a valid referral prior to their appointment date with the Queensland Paediatric Specialists clinic. By law, doctors are not able to back date referrals. GP referrals are valid for 12 months and specialists referrals are valid for 3 months only. Without a valid referral, you will not be eligible to receive any rebates from Medicare.

The doctors at Queensland Paediatric Specialists will sometimes offer internal referrals for other doctors or allied health professionals within the same clinic that they deem appropriate for your child. You are not required to accept the internal referral and are within your rights to ask for an external referral to another doctor/allied health professional located outside Queensland Paediatric Specialists.

Please turn over the page to compete consent form.

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RECORDS POLICY

I/We hereby give consent to Queensland Paediatric Specialists and its staff to collect and record information (inc. photographs/videos) in relation to my child as deemed necessary. I/We do hereby release to the Queensland Paediatric Specialists all rights to utilise these patient records in print/and or electronic form privately, or for research, educational purposes and review by other Medical Professionals.

PRIVACY POLICY

I/We understand that the Queensland Paediatric Specialists are bound by the Privacy Act. I/We therefore consent to the disclosure of any information as is necessary to provide for the care of my child and the use of email as the chosen method of communication at this practice. I understand that this consent may be withdrawn at my request at any time by informing the clinic in writing.

FINANCIAL POLICY

Any procedures and examinations conducted in this practice may incur an additional fee which is the responsibility of the parent/guardian.

TEACHING

Dr Harry Singh and the team at Queensland Paediatric Specialists is committed to improving the health of children and this includes teaching and having medical students from Bond University observe the doctors within Queensland Paediatric Specialists Clinic. If you would prefer not to have a student present during the consultation please advise our reception staff or your doctor prior to your appointment.

I, ____ consent to the handling of my child's information by this practice for the above purposes and agree that I am responsible for any additional charges incurred relating to the services provided.

Signature: ____ Date: ______________________________