Mr Raymond Yap
MBBS, BMedSci, MSurgEd, FRACS, FCSSANZ
Colorectal and General Surgeon
Laparoscopy, Robotics, TEMS/TAMIS, taTME
Open Access Colonoscopy & Gastroscopy
Colorectal Cancer, Diverticulitis, IBD
Haemorrhoids & Anorectal Disease

CR Surgery Clinic
Suite 20, Cabrini Malvern
Isabella Street, MALVERN 3144
Ph: 61 3 8376 6429
Fax: 61 3 9509 0812
Website: http://crsurgery.com.au
Email: info@crsurgery.com.au

Confidential Patient Details

Given Names: Gender:

Surname: Birthday (DD/MM/YY):

Address:

Suburb: Postcode: State: VIC

Phone: (home) (work) (mobile)

Email: Occupation:

Best Contact Person (name):

Phone: Relationship to you:

Account Details *If you are Workcover or Transport Accident Commission claim, pls advise us.*

Medicare No: Ref No:

Veteran's Affairs No: Card Colour:

Private Health Fund:

Membership No: Level of Private Insurance:

Have you had continuous private cover at this level for the last 12 months?

If not, please elaborate:

Pension No: **Full** Pension?

GP Details / Referring doctor's name (if not GP):

GP's name: Phone:

GP's clinic name:

Critical Medical History Diabetic history?

Taking blood thinning medication? Name if other:

Allergies and reaction:

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Consent to collection, storage, use and disclosure of personal health information and treatment and informed financial consent

I request Mr Raymond Yap to provide surgical assessment, advice and management as required and consented to by me. I know that I am under no obligation to take the advice or treatment course suggested and that I am free to seek a second opinion at any time.

I understand that any identifiable information collected from me, about me or about my family is confidential, will be kept securely and will only be used in the direct provision of medical assessment and treatment. This identifiable information may include letters, written notes, clinical photographs and videos. I understand that during both registration and consultation I will be asked to provide personal information including my name, address, date of birth etc. This information will be attached to all documents related to my medical record. I give my consent to Mr Raymond Yap, or their agents and advisors, to contact medical practitioners or other bodies I have consulted to obtain health and other information that may be pertinent to my care and authorise these bodies to release such information. I agree that this clinic may access My Health Record to aid in my clinical care.

I understand that my right to access my health record in most instances. I also have rights to correct any information in the record if I believe it to be incorrect. I agree to contact the practice if I wish to access or correct my record. I understand that there may a nominal fee to access this information to cover costs. I understand that my medical record will be kept in a secure place and the identifiable contents of it will not be disclosed to any person not directly involved in my primary care, except to a secondary party related to my care. Examples of disclosure to a secondary party are the disclosure of information to your health fund for billing purposes, or to another health provider involved in your care. De-identified information including photographs/videos may be used for audit, research, teaching or quality assurance such as colonoscopy re-accreditation that is run by the Gastroenterological Society of Australia and required of all colonoscopists.

I acknowledge that any services provided on my behalf may incur a fee over and above that set out in the Medicare or other schedules and that I am liable for any and all of these fees. I agree to pay these fees promptly and that there may be late fees, interest, legal and recovery costs if I do not. I understand that a Medicare rebate is only applicable if I have a valid referral. I may request a detailed breakdown of any potential fees and discuss these with Mr Yap or his staff. I recognise that, depending on medical circumstances, these fees may change. I also realise that the fees of outside agencies (hospitals, anesthetists, surgical assistants, pathology services, radiology services, paramedical personnel and any other referrals) are beyond the control of Mr Yap and cannot be accurately quoted by him. I acknowledge and consent to the use of email to communicate to me. Documents sent by the practice will generally be encrypted, however, I understand that this may not be practical, and that email is an inherently insecure form of communication and that unauthorized third parties may have access to it.

I acknowledge that by writing my name below and dating it, I signify that I agree with the above.

Name: _____ Date(DD/MM/YY): _____

If anything in the above agreement is not clear to you, please ask the staff or Mr Yap directly, before signing this document.

I wish my letters to be uploaded to MyHealthRecord: _____

Please save this form, and do one of: 1) email to info@crsurgery.com.au, 2) print it out and physically send it to us, or 3) fax it to 03 9509 0812 (no cover page required).