

Mr Raymond Yap

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

CR Surgery

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: Surname:.....

Gender (circle): Male / Female / Undisclosed Date of Birth:...../...../.....

Address:

Suburb: Postcode:..... State:.....

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: Basic Bronze Silver Gold

Have you had continuous private cover at this level for the last 12 months? YES / NO

If not, please elaborate:

Pension No:..... **Full Pension?** YES / NO

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

GP's name:..... Phone:.....

GP's address (if not on referral):.....

Critical Medical History

Are you on blood thinning medication? Aspirin Clopidogrel/Plavix Warfarin
 Other (please specify):

Allergies and reaction:

Do you have diabetes? No Diet-controlled On tablets On insulin
 On Forxiga/Qtern/Xigduo XR/Jardiance/Jardiamet/Glyxambi

PLEASE TURN OVER

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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 understand that I have a right to access my health record (in most instances). I also have the right 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 health record. I acknowledge 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 and videos may be used for audit purposes, research or teaching purposes or in the colonoscopy re-accreditation process run by GESA (Gastroenterological Society of Australia) 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. 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, anaesthetists, 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.

Signature:..... Self / Parent / Legal / Guardian / (please circle)

Name: Date:.....

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