

Moorundi Aboriginal Community Controlled Health Service Ltd. are committed to providing the best care possible, this includes primary and preventative care and chronic disease management. To enable us to carry this out please complete the following form.

PERSONAL DETAILS

NAME	
SURNAME	
DATE OF BIRTH & GENDER	DATE OF BIRTH ____/____/____ Place of Birth: _____ Male <input type="checkbox"/> Female <input type="checkbox"/> Other <input type="checkbox"/> _____
ADDRESS	_____ SUBURB: _____ POST CODE: _____
PHONE / MOBILE	
MEDICARE CARD CONCESSIONS	Ref No. _____ Expiry _____ Health Care Card <input type="checkbox"/> _____ Expiry _____ Pension Card <input type="checkbox"/> _____ Expiry _____ DVA Card No. _____ Expiry _____
ABORIGINALITY	Are you Aboriginal or Torres Strait Islander? Aboriginal <input type="checkbox"/> Torres Strait Islander <input type="checkbox"/> Both Aboriginal & Torres Strait Islander <input type="checkbox"/> Neither Aboriginal nor Torres Strait Islander <input type="checkbox"/>
CULTURAL INFORMATION	Cultural Background: _____ Country of Birth: _____ Language: _____
EMERGENCY CONTACT	Name: _____ Relationship: _____ Contact numbers _____ / _____
NDIS	Are you an NDIS Participant? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, is your plan Self-Managed <input type="checkbox"/> Plan Managed <input type="checkbox"/> Agency Managed <input type="checkbox"/> Don't Know <input type="checkbox"/>

AGED CARE	Do you receive any of the following: HCP Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, what level? 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> Who is your Provider? CHSP Yes <input type="checkbox"/> No <input type="checkbox"/> Who is your Provider?
PATIENT CONSENTS	Voicemail Messages Yes <input type="checkbox"/> No <input type="checkbox"/> SMS Reminders Yes <input type="checkbox"/> No <input type="checkbox"/>

PRIVACY AGREEMENT AND PATIENT CONSENT

I hereby acknowledge that Moorundi Aboriginal Community Controlled Health Service Ltd complies with the Privacy Act (1988) and as a part of their privacy policy Moorundi Aboriginal Community Controlled Health Service Ltd. is committed to protecting the privacy and personal information of all patients.

I have read the above and consent to Moorundi Aboriginal Community Controlled Health Service Ltd. collecting, using, storing and disposing of my personal information and authorise the release of relevant information to other health professionals to allow for premium medical care. I agree to be part of the recall register (including State and National registers), to be advised of follow up visits, medical updates and health information. I understand that Moorundi Aboriginal Community Controlled Health Service Ltd. does not disclose my personal details unless legally required. I understand that I can withdraw my consent at any time, and will need to do this in writing.

Signed: _____ Date: ____/____/____

I received assistance filling out this form/this form was filled out by someone on my behalf Yes No

If ticked yes, please fill out the information below:

Person who filled out form _____
 Relationship to client _____
 Contact number _____