EYE▲TECH Day Surgeries

Please return to
EYE ▲ TECH Day Surgeries
22 Sanders Street
Upper Mount Gravatt QLD 4122
Phone (07) 3420 2666
Toll free 1800 750 393
Fax (07) 3420 2620
Email: southside@eyetech.com.au

AFFIX LABEL HERE

Admission Pre-Registration

MR 1.1

Do not write in this space.

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Patient to Complete ▲ Please Print

▲ Identification

Title _____ Surname _____ Given Names _____

Address _____ P/Code:_____

Home Phone _____ Business Phone _____ Mobile _____

Date of Birth _____/_____/_____ Sex _____ Occupation _____

Is the patient above the age of 14 years? ☐ Yes ☐ No Marital Status _____

Email Address_____ Country of Birth _____

Is your Origin: ☐ Australian Aboriginal ☐ Torres Strait Islander ☐ Australian South Sea Islander ☐ None of the These

Language spoken at home _____ Interpreter Required? ☐ Yes ☐ No

▲ Person For Notification

Next of Kin _____ Relationship _____

Address _____ P/Code:_____

Home Phone _____ _____ Business Phone _____ Mobile _____

Emergency Contact Name _____ Contact's Phone _____

▲ Health Insurance Details

Health Fund Name _____ Type of Cover _____

Membership No _____ Do you have an excess? ☐ Yes ☐ No Amount: $_____

Have you changed your level of cover in the last 12 months? ☐ Yes ☐ No

Vet. Affairs Number _____ White Card ☐ Gold Card ☐

Workers' Compensation Claim Number _____

▲ Medical Details

Medicare Number **Number preceding your name** **Expiry**

|____|____|____|____| |____|____|____|____|____| |____| _____ _____/_____

Proposed Date of Admission _____ / _____ / _____

Eye Surgeon _____ GP _____

Consent Form Signed ☐ Yes ☐ No Recent Hospital Admission _____

Known Allergies _____

Do you have a My Health Record (previously PCEHR) ☐ Yes ☐ No

▲ Hospital Information

By ticking the following boxes I acknowledge that I have read and understood the information contained within the following:

☐ Hospital Booklet which includes the Patients Charter and Your right to privacy under the Privacy Act

I understand that **EYE ▲ TECH Day Surgeries** is a licensed Private Hospital which will invoice me for accommodation and theatre charges. I further understand that I will receive accounts from each doctor involved in my procedure. I understand that I am liable for all charges associated with the procedure to be performed. I undertake to pay all costs not reimbursed by private health insurance / an insurance claim / government departments.

_____ Date _____/_____/_____

Signature of Patient / Parent / Guardian (if under 18)

_____

Please print full name

Patient to Complete ▲ Please Print

Person Responsible for account, if other than patient:

Name _____

Address_____

Relationship _____

Signature _____ Date ____/_____/_____

▲ FOR OFFICE USE ONLY

Name of Carer _____

_____

Time Contacted: _____

Approximate Time of Return _____

Consent for the collection and Use of Personal Information

This form explains how and why we collect and use personal information and seeks your consent to certain collections and uses of that information.

The main purpose for collecting and using information is to provide you with the best possible health care. We must also comply with laws that require us to collect or disclose personal information about you. We will tell you about those legal requirements at the time that we collect the information.

If you have a My Health Record (previously called PCEHR), we will access this to assist in providing you with the best possible health care and unless you withdraw your consent at the time of your visit, we will upload our Discharge Summary to your My Health Record.

Other uses and disclosure of personal information are set out below. If you do not want us to use your personal information in one of these ways, please tick the box next to that item.

Uses of Personal Information	YES	NO
1. To train and educate professional staff.	☐	☐
2. For research projects we will undertake.	☐	☐
3. To assist in the development of service delivery and planning facilities.	☐	☐
4. To inform next of kin identified in my admission form of the outcome of treatment or to obtain consent to necessary treatment when I am not able to provide such consent.	☐	☐

Disclosures of Personal Information	YES	NO
5. To other medical practitioners, hospitals, health service providers or medical prostheses suppliers to assist in any current or future treatments that relate to the condition you are currently being treated for.	☐	☐
6. To enable Eye Tech Day Surgeries to access your information to your Health Fund if requested by the Health Fund to do so.	☐	☐
7. To enable Eye Tech Day Surgeries to access your information held by your Health Fund to assess your eligibility and provide your Health Fund with information about you if requested by your Health Fund to do so.	☐	☐
8. To provide Queensland Cancer Registry (if applicable) with details of your procedure.	☐	☐

Please note that you are entitled to obtain access to the personal information we hold about you. If you request access to a visiting medical practitioner's notes we will advise that doctor about your request.

I have read and understood this Form and except where indicated, I consent to the collection, use and disclosure of my personal information for the purposes set out in it.

Name _____ Date _____/_____/_____

Signature _____

Irrespective of any request received, I direct you NOT to provide my personal information to (please specify name/details):

_____

Signature_____ Date _____/_____/_____

Please print full name _____

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