

CARN-BRAE CLINIC

17 Errard Street North, Ballarat, VIC, 3350
Phone: (03) 5332 1501 Fax: (03) 5331 8860



Dear Patient,

We would like to take this opportunity to welcome you as a patient to our practice.

Please be advised that we are a **PRIVATE** practice, bulk billing is only applicable to **children aged under 16, DVA Card holders, and Pension Card holder aged 65 and over.**

Health Care Card holders will **NOT** be bulk-billed.

Patients will be required to settle their account in full after the consultation. A list with standard fees is located in the waiting room.

PLEASE NOTE: We are unable to accept WorkCover or TAC patients at this time.

There will be charges for non-attendance of consultations.

Dr Ahmed Alwan, Dr Frank Marton, Dr Shirani Kodituwakkuarachchi, Dr Dileepa Jayaweera & Dr Chamika Gamage.

Please sign below to indicate that you agree to our financial arrangements:

Patient Name: _____

Patient Signature: _____

SEEING DOCTOR:

- Dr Alwan Dr Marton ~~Dr Shirani~~
- Dr Jayaweera Dr Chamika

How did you find out about Carn-Brae Clinic?

- Radio Advertisement Website/Google Search Hospital/Health Professional
- Family/Friends Other - Please Specify:

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Patient Details

Family Name: Mr / Mrs / Miss / Ms _____

Given Names: _____

Date of Birth: ___ / ___ / ___ Age: _____ Gender: _____

Height: _____ Weight: _____

Cultural Background: _____

(eg. Aboriginal, Torres Strait Islander)

Address

Street: _____

Suburb: _____ Post Code: _____

Home: _____ Work: _____ Mobile: _____

Medicare and Concession Information

M/care #: _____ - _____ - ___ Ref: ___ Expiry: ___ (m)/ ___ (y)

Pension #: _____ - _____ - _____ Expiry: ___ (d)/ ___ (m)/ ___ (y)

DVA #: _____ Gold White Orange Lilac

Emergency Contact / Next of Kin

Name of Contact: _____

Relationship: _____ Phone: _____

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<u>CARDIOVASCULAR</u>	<u>YES</u>	<u>NO</u>	<u>Specify...</u>	Family History <input type="checkbox"/>
Angina / Chest Pain / AMI	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Hypertension / Hypotension	<input type="checkbox"/>	<input type="checkbox"/>	_____	
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Thromboembolism	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Cardiac Failure	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Arrhythmia	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Pacemaker / ACID Insitu / Stents	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Other Conditions	<input type="checkbox"/>	<input type="checkbox"/>	_____	
<u>RESPIRATORY</u>	<u>YES</u>	<u>NO</u>	<u>Specify...</u>	Family History <input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Pneumonia / Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Sleep Apnoea	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Cough / Sputum	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Smoker (Past or Current)	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Other Conditions	<input type="checkbox"/>	<input type="checkbox"/>	_____	
<u>METABOLIC / ENDOCRINE</u>	<u>YES</u>	<u>NO</u>	<u>Specify...</u>	Family History <input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Thyroid Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Other Condition	<input type="checkbox"/>	<input type="checkbox"/>	_____	
<u>URINARY</u>	<u>YES</u>	<u>NO</u>	<u>Specify...</u>	Family History <input type="checkbox"/>
Incontinency	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Difficulty Passing Urine	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Urgency / Frequency	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Frequent UTI's	<input type="checkbox"/>	<input type="checkbox"/>	_____	
<u>REPRODUCTIVE</u>	<u>YES</u>	<u>NO</u>	<u>Specify...</u>	Family History <input type="checkbox"/>
Gynaecological Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Other Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____	
If Female Currently Pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Currently Breastfeeding?	<input type="checkbox"/>	<input type="checkbox"/>	_____	
<u>GASTROINTESTINAL</u>	<u>YES</u>	<u>NO</u>	<u>Specify...</u>	Family History <input type="checkbox"/>
Incontinency (Faecal)	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Stoma-ileostomy / Colostomy	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Irritable Bowel Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Diverticular Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Ulcerative Colitis / Crohns	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Hiatus Hernia / Reflux	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Other Conditions	<input type="checkbox"/>	<input type="checkbox"/>	_____	

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<u>BLOOD DISORDERS</u>		<u>YES</u>	<u>NO</u>	<u>Specify...</u>	Family History <input type="checkbox"/>
Bleeding or Clotting Tendencies	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Anaemia	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Other Conditions	<input type="checkbox"/>	<input type="checkbox"/>	_____		
<u>SKIN DISORDERS</u>		<u>YES</u>	<u>NO</u>	<u>Specify...</u>	Family History <input type="checkbox"/>
Skin Disorder (Eczema / Psoriasis)	<input type="checkbox"/>	<input type="checkbox"/>	_____		
<u>MUSCULOSKELETAL</u>		<u>YES</u>	<u>NO</u>	<u>Specify...</u>	Family History <input type="checkbox"/>
Osteo / Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Fractures	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Soft Tissue Injuries	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Gout	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Bone Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Other Conditions	<input type="checkbox"/>	<input type="checkbox"/>	_____		
<u>AUTOIMMUNE DISEASE</u>		<u>YES</u>	<u>NO</u>	<u>Specify...</u>	Family History <input type="checkbox"/>
Speech / Swallowing Difficulties	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Vision Impairment	<input type="checkbox"/>	<input type="checkbox"/>	Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Prosthesis <input type="checkbox"/>		
Hearing Impairment	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Aid <input type="checkbox"/> _____		
Language Spoken			_____		
<u>IMMUNISATIONS</u>		<u>YES</u>	<u>NO</u>	<u>Date Administered</u> (if known)	
Childhood					
2 Months	<input type="checkbox"/>	<input type="checkbox"/>	___ / ___ / _____		
4 Months	<input type="checkbox"/>	<input type="checkbox"/>	___ / ___ / _____		
6 Months	<input type="checkbox"/>	<input type="checkbox"/>	___ / ___ / _____		
12 Months	<input type="checkbox"/>	<input type="checkbox"/>	___ / ___ / _____		
18 Months (born after 2012)	<input type="checkbox"/>	<input type="checkbox"/>	___ / ___ / _____		
4 Years	<input type="checkbox"/>	<input type="checkbox"/>	___ / ___ / _____		
Adult					
Tetanus	<input type="checkbox"/>	<input type="checkbox"/>	___ / ___ / _____		
Flu Vax	<input type="checkbox"/>	<input type="checkbox"/>	___ / ___ / _____		
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	___ / ___ / _____		
Cervical Vaccine	<input type="checkbox"/>	<input type="checkbox"/>	___ / ___ / _____		
<u>MEDICATIONS</u>					
Drug and Form	Strength	Dosage	Frequency		