



## **Patient Information Form & Consent**

Given name(s): \_\_\_\_\_ Surname: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Street Address: \_\_\_\_\_

Suburb: \_\_\_\_\_ State: \_\_\_\_\_ Postcode: \_\_\_\_\_

Postal Address (if different from street address): \_\_\_\_\_

Contact Numbers: (Home) \_\_\_\_\_ (Mobile) \_\_\_\_\_

Email Address: \_\_\_\_\_

I give consent for the practice and doctor to communicate with me by e-mail YES / NO  
including attachment of letters and results

I give consent for the practice and doctor to communicate with me by SMS YES / NO

Occupation: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Medicare Number: \_\_\_\_\_ Ref: \_\_\_\_\_ Expiry: \_\_\_\_\_

Pensioner Number: \_\_\_\_\_ Expiry: \_\_\_\_\_

DVA (Vet Affairs) Number: \_\_\_\_\_ Gold White

Private Health Fund: \_\_\_\_\_ Membership Number: \_\_\_\_\_

Do you have hospital cover with your private health insurance? Yes / No

Usual GP (if different from the referring Doctor): \_\_\_\_\_

Medical Centre/Practice Name: \_\_\_\_\_

Emergency/NOK Contact Details:

Name: \_\_\_\_\_ Contact Number: \_\_\_\_\_

Email Address: \_\_\_\_\_ Relationship: \_\_\_\_\_

Vaccination status: First  Second  Booster  Unvaccinated

*Please turn over...*

### **Patient Consent & Privacy Act**

The Privacy Act of 1988 requires medical practitioners to obtain patient consent to collect, use and disclose their personal information. The practice staff and medical practitioners may participate in the collection of information required to treat and advise you.

This includes: *Full medical history, family medical history, ethnicity, genetic information, contact details; Medicare/private health fund, billing and account details, information obtained from other sources, for example, (1) Other doctors (current or former), allied health professionals, dentists, hospitals and day surgery units, or (2) Relatives or other sources, in emergency situations where we cannot obtain your prior express consent.*

#### **Disclosure and use:**

With your consent, the information is used and disclosed for:

- (1) *Referral to other medical practitioners, health care providers or hospital for treatment options, sending of specimens for analysis, practice management, audit, quality assurance, accreditation, complaint handling, account keeping, billing*
- (2) *To meet our obligations of notification to our medical defence organisations or insurers, to prevent or lessen a serious threat to an individual's life, health or safety and where legally required to do so, for example, producing records to court, mandatory reporting of child abuse or notification of diagnosis of certain communicable diseases*

#### **Financial Consent:**

Swan Urology operates as a private billing practice. All consultation invoices are to be paid on day of appointment and can be sent to Medicare for rebates. At the doctor's discretion, fees may be reduced if you are a pension card holder.

#### **Consultation Fees:**

##### **Initial / Long Consultation (MBS Item 104):**

Cost: \$250.00                      Medicare rebate: \$76.15

##### **Review Consultation (MBS item 105):**

Cost: \$110.00                      Medicare Rebate \$38.25

#### **Operation Outcome Disclosure:**

As part of continuing professional development, a surgeon is responsible for analysing operation outcomes and presenting these results for peer review. Relevant medical information collected for all patients may be used in this audit. The surgeon is bound by strict ethical regulations to de-identify the information so that it cannot be traced to an individual patient. Please discuss this with your surgeon if you have concerns or do not wish to participate in this process.

#### **CONSENT**

- I provide my consent for Dr Ooi to collect, use and disclose my personal information as outlined above.
- I understand that I am entitled to access my own health records except where access would be denied as outlined above.
- I authorise the disclosure of all past and present protected health information requested by Dr Ooi from health care professionals, hospitals or organisations.
- I understand that I may withdraw my consent as to use and disclosure of my personal information (except when legal obligations must be met).
- I am responsible for full payment of account fees, on the day of the consultation.
- I provide my consent for Dr Ooi to perform a flow test and bladder ultrasound during the consult.

Patient Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

## HEALTH INFORMATION QUESTIONNAIRE

FULL NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_

PREVIOUS/CURRENT OCCUPATION(S): \_\_\_\_\_

EXPOSURE TO RADIATION, PESTICIDES, DYES, HEAVY METALS, PETROLEUM? YES NO

FAMILY HISTORY OF CANCER: \_\_\_\_\_

<b>CARDIOVASCULAR</b>	
Heart disease	
Bypass surgery	
Heart valve	
Pacemaker or defibrillator	
Cardiac stent	
High cholesterol	
Hypertension	
Stroke	
TIA (mini-stroke)	
Peripheral vascular disease	
<b>RESPIRATORY</b>	
Emphysema/COPD	
Sleep apnoea	
CPAP machine	
Asthma	
<b>DIABETES MELLITUS</b>	
Diet controlled	
Tablets	
Insulin	
<b>KIDNEYS</b>	
Chronic kidney disease	
Dialysis	
Kidney transplant	
Kidney stones	
Solitary kidney	
Kidney surgery	

<b>OTHER</b>	
Epilepsy	
Glaucoma	
Frequent falls	
Incontinence surgery	
Prolapse surgery	
Cervical or womb cancer	
Bowel cancer	
Radiation therapy	
Gall bladder surgery	
Appendicectomy	
Dementia	
HIV/AIDS or hepatitis B,C	
<b>SMOKING</b>	
Age when started	
Age when stopped	
Packs smoked/day	
<b>ALLERGIES</b>	
None	
Antibiotics	
Plasters/latex	
Other	
<b>SOCIAL</b>	
Travel to remote Asia	
Travel to Africa	

**MEDICATIONS** (especially chemotherapy, immune suppressing drugs, blood-thinning drugs such as aspirin, clopidogrel, plavix, warfarin, non-steroidal anti-inflammatory drugs, prednisolone, steroids, insulin)

---



---

## VOIDING ASSESSMENT FEMALE

	Not at all	Less than one time in five	Less than half the time	About half the time	More than half the time	Almost always
<b>How many times do you typically urinate from waking in the morning until sleeping at night?</b>	Every 4 hours or more	Every 3-4 hours	Every 2-3 hours	Every 1-2 hours	At least once an hour	
<b>How many times do you typically wake up to urinate from sleeping at night until waking in the morning?</b>	0	1	2	3	4	5
<b>How often do you have a sudden desire to urinate, which is difficult to defer?</b>	Not at all	Less than once a week	Once a week or more	About once a day	2-4 times a day	5 times a day or more
<b>How often do you leak urine because you cannot defer the sudden desire to urinate?</b>	Not at all	Less than once a week	Once a week or more	About once a day	2-4 times a day	5 times a day or more
<b>Once you get the urge or desire to urinate, how long can you usually postpone it comfortably?</b>	More than 60 minutes	About 30-60 minutes	About 10-30 minutes	Less than 10 minutes	Must go straight away	
<b>How often do you get a sudden urge or desire to urinate that makes you want to stop what you are doing and rush to the bathroom?</b>	Never	Rarely	A few times a month	A few times a week	At least once a day	
<b>How often do you get a sudden urge or desire to urinate but you do not get there in time? (leak urine or wet pads)</b>	Never	Rarely	A few times a month	A few times a week	At least once a day	
<b>On average, how many glasses of water do you drink a day?</b>	More than 8	7-8	5-6	3-4	1-2	None
<b>On average, how many cups of coffee do you drink a day?</b>	0	1	2	3	4	5 or more
<b>On average, how many cups of tea do you drink a day?</b>	0	1	2	3	4	5 or more
<b>On average, how many standard drinks of alcohol do you drink a day?</b>	0	1	2	3	4	5 or more
<b>If you were to spend the rest of your life with your urinary condition just the way it is now, how would you feel about that</b>	Delighted	Pleased	Mostly satisfied	Mixed	Unhappy	Terrible

Have you ever seen blood in your urine?                      Y        N

Have you ever had a urinary tract infection?                      Y        N