Professor Brian K. Owler
MB BS BSc(Med)(Hons) PhD FRACS

Neurosurgeon
Adult and Paediatric

Suite 312, Q Central
10 Norbrik Drive
Bella Vista NSW 2156
Sydney, Australia

Patient Information Form
Confidential

Personal Information

Surname _____ First Names _____

Date of Birth _____ Age _____ Height _____ Weight _____

Address _____ Telephone _____

_____ Postcode _____ Mobile _____

Occupation _____ Email _____

I give permission for my clinical and financial information to be emailed to myself or others at my request. I understand that SPN can only guarantee the security of our own systems and cannot guarantee security of email beyond our systems
Signed _____
Print Name _____

Medicare / Health Fund Information

Medicare Number _____ Expiry __ Ref:

Health Fund _____ Membership Number _____

Aged Pension /DSP Pension / Veterans Affairs DVA number:

Next of Kin / Contacts

Name _____ Phone _____Relationship_____

Name _____ Phone _____Relationship_____

Referring Doctor

Name _____ Specialty _____

Address _____

_____ Provider Number _____

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General Practitioner (if different to referring doctor)

Name _____ Specialty _____

Address _____

_____ Provider Number _____

Other Relevant Specialists eg Cardiologist

Name _____ Specialty _____

Name _____ Specialty _____

Name _____ Specialty _____

Reason for Referral

_____

_____

_____

Alcohol / Smoking

Are you or have you been a smoker? Yes / No

If yes please state when and how much _____

Do you drink alcohol? Yes / No

If yes please state when and how much _____

Blood Thinners

Do you take Aspirin, Cartia, Dispirin/Cardiprin etc Yes / No

Do you take blood thinning medication eg Warfarin, Persantin, Plavix,

Dipyridamole, Ticlopidine etc Yes / No

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Medications

_____

_____

_____

_____

_____

_____

Allergies

_____

_____

_____

Please indicate relevant issues

Heart Disease	☐ High Blood Pressure ☐ Angina ☐ Abnormal Heart Beat	☐ High Cholesterol ☐ Heart Attacks ☐ Heart Failure	Others
Lung Disease	☐ Asthma ☐ Chest Infections	☐ Bronchitis ☐ Emphysema	Others
Gastric	☐ Peptic Ulcer ☐ Gall Bladder	☐ Hepatitis ☐ Liver Failure	Others
Renal / Kidney	☐ Bladder Infections ☐ Kidney Stones	☐ Kidney Infections ☐ Kidney Failure	Others
Neurological	☐ Strokes ☐ Epilepsy	☐ Dizziness ☐ Foot drop	Others
Endocrine	☐ Diabetes ☐ Osteoporosis	☐ Thyroid Disease	Others
Malignancy	☐ Brain Tumour ☐ Breast Cancer ☐ Bowel Cancer	☐ Lung Cancer ☐ Prostate Cancer ☐ Skin cancer	Others

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Please state other relevant medical history

_____

_____

_____

_____

_____

Major surgical procedures

_____

_____

_____

_____

_____

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Collection of Information Statement

This medical practice collects information from you for the primary purpose of providing quality health care. We require you to provide us with your personal details and a full medical history so that we may properly assist, diagnose and treat illnesses and be pro-active in your health care. We will also use the information you provide in the following ways:

- Administrative purposes in running our medical practice
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements
- Disclosure to others involved in your health care, including treating doctors and specialists outside this medical practice, pathology and imaging services.

I have read the information above and understand the reasons why my information must be collected. I understand that I am not obliged to provide any information requested of me, but that my failure to do so might compromise the quality of the health care and treatment given to me.

I am also aware that this practice has a Privacy Policy which I am entitled to have access to on request. This Policy complies with the Privacy Act 2014 and aligns with the Australian Privacy Principles in relation to storage and access of your clinical and sensitive information.

I understand that if I request access to information about me, the practice will be entitled to charge fees to cover time and administrative costs which may not be covered by a Medicare rebate.

I understand that if my information is to be used for any purpose other than set out above, my further consent will be obtained.

I consent to the handling of my information by this practice for the purposes set out above, subject to any limitations on access or disclosure that I notify this practice of.

Signed:_____ **Date:** _____

On occasion Professor Owler my wish to use images and scans for teaching, demonstration and consultative purposes. These images and/or scans will be de-identified prior to use.

I **do give** permission for Professor Owler to use my de-identified images and/or scans for the purpose outlined above

Signed _____ Date_____

I **do not give** permission for my images and/or scans to be used for the purpose as outlined above

Signed _____ Date_____