PATIENT INFORMATION SHEET

Name: (Dr/Mr/Mrs/Miss/Ms) (first name) (surname)

Date of Birth:

Address:

Postcode:

Telephone: home work

other Preferred for Confirming apts

Emergency contact

Contact No:

Medicare No: Exp Date: Ref No

Referring Doctor:

Phone No:

Usual GP(if different from above)
Phone

Do you provide consent for your psychiatrist to correspond with your referring GP and other clinicians involved in your care? Yes No

Can we leave messages to Confirm appointments Yes No

Can we speak to family members to confirm/make appointments Yes No

Signature for receiving Doctor's information sheet

This Practice is committed to comply with the *Privacy Act 1988* and all amendments to the Act. The Practice will ensure respect for consumer privacy in handling all patient information. All reasonable steps will be taken to comply with the Act