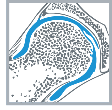
MELBOURNE ORTHOPAEDIC CLINIC



CONFIDENTIAL NEW PATIENT FORM

Name:

Mr Justin Hunt
MBBS FRACS
ORTHOPAEDIC & SPINAL SURGEON

PATIENT DETAILS

☐ Mr ☐ Mrs ☐ Master ☐ Miss ☐ Ms ☐ Dr ☐ Prof ☐ Other

Date of Birth: _____/_____/__________

Surname: ______________________ **Given Name:** ______________________

Known as: ______________________

Home Address: ______________________

Suburb: ______________________ **Postcode:** __________

Email: ______________________

Occupation: ______________________

Telephone Numbers:

Home: __________ Work: __________ Mobile: __________

Next of kin details (family member or friend / medical power of attorney)

Name: ______________________ Relationship to you: __________

Next of Kin Contact number: ______________________

Referring Doctor: ______________________

Address: ______________________

Telephone: __________ Fax: __________

Usual GP Name: ______________________

Address: ______________________

Telephone: __________ Fax: __________

Physiotherapist: __________ Tel: __________ Fax: __________

Address: ______________________

Other interested Medical Practitioners: ______________________

Practice Details: ______________________

Telephone: __________ Fax: __________

MEDICARE & HEALTH INSURANCE

Medicare Number: ______________________ Ref No: __________ Exp Date: __________

Private Health Insurance: ☐ Yes ☐ No **Fund Name:** ______________________

Membership Number: ______________________

Veterans Affairs Card ☐ Yes ☐ No **No:** __________ ☐ White ☐ Gold Exp Date: __________

Public / Uninsured Patient: ☐ Yes ☐ No

[Form Last Updated February 28, 2017]

MAIN ROOMS:
15 Erin Street
RICHMOND VIC 3121

Tel: (03) 9421 6199
Fax: (03) 9421 6114

Consulting at:
Richmond Frankston Swan Hill

MELBOURNE ORTHOPAEDIC CLINIC

Mr Justin Hunt
ORTHOPAEDIC & SPINAL SURGEON

Name:

MEDICAL HISTORY & MEDICATIONS

CARDIAC: PACEMAKERS and/or IRREGULAR HEARTBEAT

I have had an irregular heartbeat or palpitations: ☐ Yes ☐ No

Do you have a pacemaker and /or defibrillator? ☐ Yes ☐ No If yes type/brand: ____

Do you have a Cardiologist? ☐ Yes ☐ No **Cardiologist's Name:** ____

Cardiologist: Address & Contact Details: ____

I have been hospitalised for a heart attack and/or have had surgery on my heart: ☐ Yes ☐ No If yes: ☐ Stent ☐ Bypass Surgery ☐ Valve

BLOOD-THINNING MEDICATIONS

Do you take Asprin / Cartia? ☐ Yes ☐ No Details: ____

Do you take any of the following medications? (please tick)

☐ **Clopidogrel** (Plavix or Iscover) ☐ **Asasantin** ☐ **Warfarin** ☐ **Clexane** ☐ **Dabigatran (Pradaxa)**

☐ **Fondaparinux (Arixtra)** ☐ **Rivaroxiban (Xarelto)** ☐ **Eliquis** ☐ I do not take any blood thining medications

Details: ____

Have you ever had a bleeding or clotting problem? ☐ Yes ☐ No

Details: ____

Have you ever had a stroke or mini-stroke/TIA? ☐ Yes ☐ No

Details: ____

DIABETES:

Do you suffer from Diabetes? ☐ Yes ☐ No If yes: ☐ Type 1 or ☐ Type 2

If Yes, is your Diabetes controlled by: ☐ **Diet Only** ☐ **Tablets/Medication** ☐ **Insulin Injections**

Do you have a Endocrinologist? ☐ Yes ☐ No **Endocrinologist's Name:** ____

Endocrinologist: Address & Contact Details: ____

Do you have any additional specialists managing your care? ☐ Yes ☐ No **Name:** ____

Specialist's: Address & Contact Details: ____

CURRENT MEDICATIONS

Please list all medications: (include aspirin, cortisone, steroids, anti-inflammatory, warfarin, herbal products and over-the-counter preparations)

Drug name	Dosage	Frequency	Drug name	Dosage	Frequency

ALLERGIES: Do you have any allergies? (ie Medications / Tapes / Dressings / Latex / Contrast) ☐ Yes ☐ No

If yes please list and include details of reaction: ____

www.melbourneorthopaedicclinic.com.au
All Appointments, Enquiries & Correspondence to our Richmond Practice Only
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HIP • KNEE • SHOULDER • SPINE

MELBOURNE ORTHOPAEDIC CLINIC

CONFIDENTIAL
NEW PATIENT FORM

Mr Justin Hunt
ORTHOPAEDIC & SPINAL SURGEON

Name:

PREVIOUS OPERATIONS

Please list previous surgical procedures: ______________________________

Operation: ______________________________ Year Performed: ______________

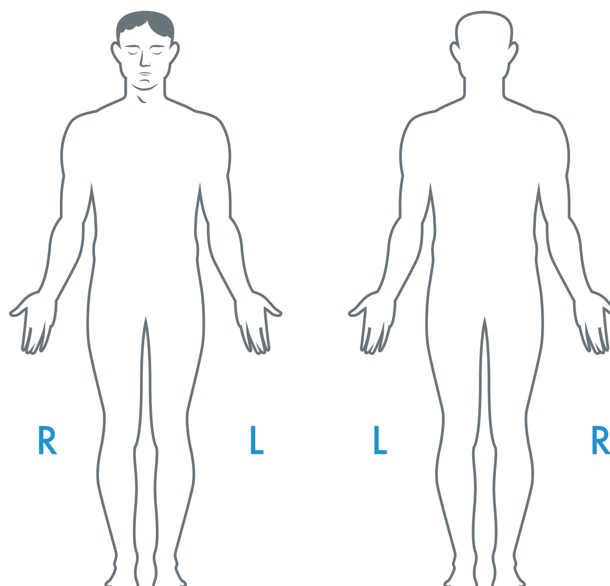
Operation: ______________________________ Year Performed: ______________

Operation: ______________________________ Year Performed: ______________

Have you ever had problems with an anaesthetic previously? ☐ Yes ☐ No If yes, please describe: ______________

BODY PART(s) INJURED / AREA of CONCERN

TELL US BRIEFLY ABOUT YOURSELF AND YOUR CONDITION



History of Injury *(e.g. fell whilst playing sport)*

Your Current Symptoms	**Pain:**	☐ Mild	☐ Moderate	☐ Severe
	Pain Duration:	☐ Constant	☐ Intermittent	☐ Worse on movement
	Do You Experience:	☐ Swelling	☐ Weakness	☐ Numbness

Normal Work / Sporting Activities:

What Aggravates Your Symptoms?

What Relieves Your Symptoms?

How Far Can You Walk?

Previous Bone or Joint Surgery:

Please List Any Specific Concerns / Questions You have regarding your injury/condition:

[February28,2017]

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MELBOURNE ORTHOPAEDIC CLINIC

CONFIDENTIAL NEW PATIENT FORM

Mr Justin Hunt
ORTHOPAEDIC & SPINAL SURGEON

Name:

CONSENT

We require your consent to collect personal information about you. Please read this information carefully and sign where indicated below.

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 assess, diagnose, treat and be proactive in your health care needs.

We will use the information you provide in the following ways:

- Administration purposes in running our medical practice.
- Billing purposes, including compliance with Medicare, Health Insurance Commission, Workcover and Transport Accident Commission requirements.
- Disclosure to others involved in your health care, including treating doctors, physiotherapists and other specialists outside the medical practice. This may occur through referral to other doctors or for medical investigations and in the reports of results returned to us following referrals.

I have read the information above and understand the reasons why my information must be collected. I am also aware that this practice has a privacy policy on handling patient information.

I understand that I am not obliged to provide any information requested of me, but that my failure to do so may compromise the quality of health care and treatment given to me.

I am aware of my right to access the information collected about me, except in some circumstances where access might legitimately be withheld. I understand I will be given an explanation in these circumstances.

I understand that if my information is to be used for any other 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.

Signature: ______________________ **Date:** ___/___/______

Name: *(Please Print)* ______________________

CONSENT TO PARTICIPATE IN RESEARCH

I ______________________ *am willing to participate in the collection of data for research purposes.*

(All data is de-indentified)

Signature: ______________________ **Date:** ___/___/______

Name: *(Please Print)* ______________________

REFERRAL SOURCE

How did you hear about Mr Justin Hunt? Referred by Doctor: ☐ GP or ☐ Specialist ______________________

☐ Website – www.melbourneorthopaedicclinic.com.au ☐ or Royal Australian College of Surgeons (RACS) website

☐ Google ☐ Yellow Pages ☐ White Pages ☐ Personal recommendation: ______________________

☐ Other: ______________________

PLEASE NOTE:
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Melbourne Orthopaedic Clinic
15 Erin Street
RICHMOND VIC 3121

Tel: (03) 9421 6199
Fax: (03) 9421 6114
Email: admin@moc.com.au

CONSULTING AT:

☐ RICHMOND
Erin Street
RICHMOND VIC 3121

☐ FRANKSTON
Peninsula Private Hospital
Specialist Consulting Rooms
Suite 3/525 McClelland Drive
FRANKSTON VIC

☐ SWAN HILL
Swan Hill Medical Centre
Specialist Rooms
cnr Splatt & McCrae Streets
SWAN HILL VIC 3585

[February28,2017]