Mr Stefan Ponosh MBBS FRACS (Vascular)

Vascular & Endovascular Surgeon

Surname:					Mr / Mrs / Ms / Miss
First name/s:					
Address:					
Suburb:			Post Code:		
Telephone:	Home:				
	Mobile:				
	Work:				
Email:					
Date of Birth:			Age:		
Occupation:					
Next of Kin:			Relationship:		
Telephone:			Mobile:		
Medicare No:		-	Ref No:	Expiry:	
Private Health Fund:			Membership No:		
Level of Cover/ Plan:			Hospital Cover:	Yes / No	
DVA No:			Card Colour:		
Pension No:			Expiry Date:		
Workers Compensation	Yes / No		Motor Vehicle Accident:	Yes / No	
Referring Dr / Specialist:					
Address:					
Suburb:			Post Code:		
Telephone:					
Family Doctor / GP:					
Address:					
Suburb:			Post Code:		
Telephone:					

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PATIENT CONFIDENTIALITY

Family members and/or friends often contact Doctors to enquire about a patient's care or proposed treatment.

This practice has a strict confidentiality policy that prohibits discussion of a patient's medical details without the patient's prior authorisation, *with the exception* of communication between a patient's General Practitioner and/or Referring Doctor.

To ensure that we have your consent and that we are properly informed about who you authorise Mr Ponosh and/or his practice staff to discuss your care and/or medical information with, please advise us by completing the information below.

Please cross out any clause that you do not agree with, sign and date this Confidentiality form.

I, _____ , hereby authorise Mr Ponosh and/or his practice staff to:

1. Discuss my care with my nominated next of kin only.

OR

2. Discuss my care with the members of my family or friends specified below:

Name	Next of Kin / Family Member / Friend

OR

3. Advise that Mr Ponosh and/or his staff are not authorised to discuss my care with any member of my family or friends, and may only discuss my care with my nominated next of kin in an emergency.

Patient's Signature: _____ Date: _____

REASON FOR REFERRAL: _____

_____

_____

PAST MEDICAL HISTORY: _____

_____

_____

_____

_____

PAST SURGERY: _____

_____

_____

_____

_____

ALLERGIES: **CONTRAST / DYES / SHELLFISH / IODINE**

Other Allergies: _____

Reaction: _____

CURRENT MEDICATIONS:

Drug:	Dose:	Frequency:	Reason for taking: