PATIENT REGISTRATION

Dr Margaret Leach – Gastroenterologist

Please complete and sign, **attach your referral and any relevant blood tests/scans** and return via email/mail or Fax.

Have you seen Dr Leach before? No ◯ **Yes** ◯ **Year? _____**

Surname			Given Name		
Date of Birth		Weight		Height	
Address					
Suburb			Post Code		
Mobile			Home		
Email			Occupation		
Relationship Status	Single ◯	Married ◯	De Facto ◯	Widowed ◯	Divorced ◯
Emergency Contact Name					
Phone Number			Relationship		
Medicare Number					
Ref. No			M/C expiry date		
Private Health Fund			Membership No		
DVA No			DVA Class		
Pension No			Pension expiry date		
Usual GP			Telephone		
Practice Address					
Suburb			Post Code		
Referring Doctor			Telephone		
MEDICAL HISTORY – PATIENT TO COMPLETE					
Are you diabetic?			Yes ◯	No ◯	
Reason for referral					
Consultation required?	Yes ◯		No ◯	Unsure ◯	
Procedure required?	Yes ◯		No ◯	Unsure ◯	
If so, which procedure?	Colonoscopy ◯		Gastroscopy ◯	Both ◯	

Suite 4304, Level 3, Dee Why Grand, 834 Pittwater Rd, Dee Why NSW 2099
P: 02 9972 4660 E: admin@drmargaretleach.com.au F: 02 9972 4661 W: www.drmargaretleach.com.au

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Have you had or do you currently have any of the following?

Family history of colorectal cancer			
Age of relative when diagnosed and relationship to you			
Diabetes	Yes ◯	Type	No ◯
Heart Attack	Yes ◯		No ◯
Heart Murmur	Yes ◯		No ◯
Irregular Heart Beat	Yes ◯		No ◯
Clotting Disorder	Yes ◯		No ◯
Are you on any blood thinners?			
Do you smoke?	Yes ◯	How many	No ◯
How much alcohol do you drink weekly? (10gms=1 middy beer,1 nip,125ml wine)			
Any other surgery/medical conditions?			
Do you have any allergies - what reaction?			
Have you been vaccinated against Covid-19?		Have you had Covid (date of diagnosis)	
Do you have any special needs?			
Do you have any family history of gastrointestinal disease?			

Please list <u>ALL</u> medication & dosage you are currently taking (incl. supplements/vitamins)

<u>PRIVACY INFORMATION</u> We collect information from you so we can assess, diagnose & treat your illnesses & be proactive in your health care. We will also use the information you provide in the following ways: Administration of this Medical Practice; Billing, including compliance with Medicare requirements; Disclosure to others involved in your health care, including Drs and Specialists outside this practice who may become involved in treating you (i.e. referral to Drs, tests and in quality studies). 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 about which I notify this practice now or any future time. I acknowledge that I have read this form before signing it and that a member of the staff of this practice has at my request clarified any aspects of it that I did not understand.

<u>FINANCIAL INFORMATION</u> I also accept financial responsibility for payment of Dr Leach's services and I have read her fee information below. Dr Leach's Consultation Fees: 1st Visit/New Referral $400.00 or complex 1st visit $500.00. Follow up visit $180.00 or complex $210.00. Patients on a disability pension will be bulk billed.

Signed …… **Date** ……

Type your name or place your signature on the line above

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