PATIENT DETAIL FORM

SURNAME: ……..…**MR MRS MISS MS DR** *(please circle)*

FIRST/OTHER NAMES: ……..…..**KNOWN AS**……..……..

ADDRESS:……

……..……

TOWN/CITY: …….. **STATE:** ……..…**POSTCODE**……..

COUNTRY OF BIRTH …….. **FIRST LANGUAGE** English Other ……..

ABORIGINAL OR TORRES STRAIT ISLAND DESCENT Yes No Not disclosed
DATE OF BIRTH: ……..…… **PHONE No:** *(Home):* ……

MOBILE: ……..…… **WORK:** …….. **FAX:** ……..……..

EMAIL ADDRESS:……..……..

MEDICARE No: ……..…….. **Patient ID No:** ……... **Expiry Date:** ……/ ……..

HEALTH CARE CARD/PENSION No: .....

DEPT VETERAN AFFAIRS number: *(if applicable)*…….. **Gold / White card**
(please circle)

PRIVATE HEALTH FUND NAME: ……..……..
Cover Level *(please circle)* *Top *Intermediate *Basic

PRIVATE HEALTH FUND NO: ……..…….. **PNT ID NO:** ……..

WORKCOVER: .....CLAIM NO:.....

USUAL GENERAL PRACTIONER: ……..……..

ADDRESS OF GENERAL PRACTITIONER: ……..……..……

NEXT OF KIN *(Name):* …… **(Relationship to Patient)** ……..……

Contact Phone No: ……..…….. **Mobile No:** ……..……..

2nd CONTACT *(Name):* ……

(Relationship to Pnt) ……. **Contact Ph:** ……..…… **Mobile:**……..……

3rd CONTACT *(Name):* ……

(Relationship to Pnt) ……. **Contact Ph:** ……..…… **Mobile:**……..……

If necessary, I give permission for my Medical Information to be disclosed to: *(Please specify below eg spouse, parent, child, solicitor, power of medical attorney)*

……..……..……**Relationship:** ……..……..……..

Name of Power of Medical Attorney (if applicable):……..……..

Please do not discuss my medical condition with: ……..……..

Messages can / cannot be left on: *state (home, work, mobile number)*……..

Signature: …….. **Date:** ……

TESTS & PROCEDURES

Patient Name: _____

To ensure that our specialists have all your current medical information, please indicate below if you have had any of the following tests/procedures.

Please bring any results associated with these tests/procedures with you on the day of consultation, if not already provided by your referring practitioner.

Please Tick:

Tick	Test Result	Where?	When?
	Blood Tests		
	CT Scan		
	X-Rays		
	Pet Scans		
	Nuclear Scan		
	Bone Marrow Biopsy		
	Surgery		
	Hospital Admissions		
	Other tests ordered by another specialist or GP		

Are you taking Warfarin (or any blood thinning agents? ☐ **Yes** ☐ **No**

Are you a Diabetic? ☐ **Yes** ☐ **No**

Thank you for your assistance in this matter

Patient History Form

Please help us to improve our service to you by filling in the information required as completely as possible. Some examples of information required are provided in italics. Please complete all sections or write **Not Applicable** if not relevant. Do not worry if you are unable to answer all the questions.

Last Name : _____ Given Name:_____ DOB: _____

Address: _____

Provide a brief history of your present illness:

_____

_____

_____

List all previous operations

Operations	Date	Surgeon / Hospital

List any major illnesses that you've been diagnosed with eg high blood pressure, diabetes.

Illness	Year of Diagnosis

List all medications that you take (incl vitamins & non-prescription medication).

Medicine (dose, how often taken?)	Doctor / Clinic

List all family members that have been diagnosed with cancer, or any other significant illness:

Illness / Relationship	Date/Age Diagnosed	Alive/ Deceased	Treated: How/When/Where

Do you have any allergies? YES / NO Please list them

Allergic to	What happens if you come into contact with it	Since when?

Patient History Form – cont….

Smoking History (select and fill in please):

Never Smoked	Previously (stopped > 1 month ago)	Smoker
Started (year):	Stopped (year):	Average cigarettes per day:

Do you drink alcohol? ☐ Yes ☐ No

How many alcoholic drinks do you drink per day on average?
What type of alcohol to you drink most often?
Have you ever been treated to help you stop using alcohol?
Have you ever been admitted to hospital for alcohol related illness?

Are you?

☐ Single
☐ Married
☐ Divorced
☐ Widowed
☐ Disabled
☐ Pensioner
☐ Parent with dependent children

What is your occupation?_____

What is your main hobby?_____

What sport/s do you participate in?_____

Does your religion prevent any treatment?_____
Please explain_____

Please rate severity of any relevant symptoms that have troubled you significantly in the past 6 mnths

.

0 = not present 1= Mild 2 = Moderate 3 = Severe

Symptom	*Score*	***Symptom***	*Score*	***Symptom***	*Score*
Weight loss		Fatigue		Diarrhoea	
Nausea		Vomiting		Constipation	
Pain		Difficulty swallowing		Headache	
Swelling of legs		Stomach cramps		Stomach swelling	
Blood in the bowel motion		Coughing		Jaundice (appearing yellow)	
Lumps under skin		Shortness of breath		Skin rash	
Sweats		Coughing up blood		Itching	
Heartburn		Dizziness		Loss of appetite	
Depressed mood		Anxious		Difficulty sleeping	

Please provide details on the most troubling symptoms (how long have you had them, how do they affect you?: _____
_____
_____

Are you dependent on other people to perform your normal activities (e.g. dressing, showering, house cleaning, shopping, cooking, meal preparation)? If yes give details.

_____

Who do you live with?

_____

What sort of accommodation do you live in (eg house, flat/unit, farm)? _____

Does your accommodation have steps? _____If so, how many? _____

Please list names of all doctors you regularly see:

_____

APPOINTMENT CANCELLATION POLICY AGREEMENT:

Border Medical Oncology is committed to providing all of our patients with care in a timely fashion. When a patient is either a "No show" or cancels their appointment without giving enough notice, they prevent another patient from being seen.

Please call us on 02 6064 1515 at least 48 hours prior to your scheduled appointment to notify us of any changes or cancellation. To cancel a Monday appointment, please call our office by 11:00am on the prior Friday.

If prior notification is not given, Doctors reserve the right to charge a "Did not attend" fee of $35.00 for the missed appointment and you will be seen when an appointment is next available.

Please sign below to acknowledge to these terms.

_____ _____

Patient signature (or guardian) Date

Safeguarding Your Privacy

Introduction

Our practice is committed to best practice in relation to the management of information we collect. This practice has developed a policy to protect patient privacy in compliance with the Privacy Act 1988 (Cth) ('the Privacy Act'). Our policy is to inform you of:

- the kinds of information that we collect and hold, which, as a medical practice, is likely to be 'health information' for the purposes of the Privacy Act;
- how we collect and hold personal information;
- the purposes for which we collect, hold, use and disclose personal information;
- how you may access your personal information and seek the correction of that information;
- how you may complain about a breach of the Australian Privacy Principles and how we will deal with such a complaint;
- whether we are likely to disclose personal information to overseas recipients;

What kinds of personal information do we collect?

The type of information we may collect and hold includes:

- Your name, address, date of birth, email and contact details
- Medicare number, DVA number and other government identifiers, although we will not use these for the purposes of identifying you in our practice
- Other health information about you, including:
  - notes of your symptoms or diagnosis and the treatment given to you
  - your specialist reports and test results
  - your appointment and billing details
  - your prescriptions and other pharmaceutical purchases

How do we collect and hold personal information?

We will generally collect personal information:

- from you directly when you provide your details to us. This might be via a face to face discussion, telephone conversation, registration form or online form
- from a person responsible for you
- from third parties where the Privacy Act or other law allows it - this may include, but is not limited to: other members of your treating team, diagnostic centres, specialists, hospitals, electronic prescription services, Medicare, your health insurer, the Pharmaceutical Benefits Scheme

Why do we collect, hold, use and disclose personal information?

In general, we collect, hold, use and disclose your personal information for the following purposes:

- to provide health services to you
- to communicate with you in relation to the health service being provided to
- when it is required by law
- to help us manage our accounts and administrative services, including billing, arrangements with health funds, pursuing unpaid accounts,
- for consultations with other doctors and allied health professional involved in your healthcare;
- to obtain, analyse and discuss test results from diagnostic and pathology laboratories
- for identification and insurance claiming
- Information can also be disclosed through an electronic transfer of prescriptions service.
- To liaise with your health fund, government and regulatory bodies such as Medicare, the Department of Veteran's Affairs and the Office of the Australian Information Commissioner (OAIC) (if you make a privacy complaint to the OAIC), as necessary.

How can you access and correct your personal information?

You have a right to seek access to, and correction of the personal information which we hold about you. There will be a fee for this which is dependant on the total number of pages required to be collated. We will normally respond to your request within 30 days.

How do we hold your personal information?
Our staff are trained and required to respect and protect your privacy. We take all reasonable steps to protect information held from misuse and loss and from unauthorised access, modification or disclosure. Our practice stores all personal information securely via electronic format in protected information systems.

Privacy related questions and complaints
We take complaints and concerns regarding privacy seriously. You should express any privacy concerns you may have in writing to the below address and we will then attempt to resolve it in accordance with our resolution procedure. We will normally respond to your request within 30 days.
The Privacy Officer, Border Medical Oncology and Haematology
Level 1, 201-239 Borella Road, East Albury NSW 2640
Ph: 02 6064 1515 Fax: 02 6064 1516 E-mail: mail@bordermedonc.com.au

You may also contact the OAIC:
GPO Box 5218 , Sydney NSW 2001
Phone: 1300 363 992 **Fax:** +61 2 9284 9666 **Email:** enquiries@oaic.gov.au
Website: https://www.oaic.gov.au/individuals/how-do-i-make-a-privacy-complaint

Privacy and websites
We endeavour to ensure our website is as secure as possible; however, users need to be aware that the World Wide Web is not a secure medium. Border Medical Oncology and Haematology take no liability for any interference or damage to a user's computer system, software or data occurring in connection with our website. We strongly recommend user's take appropriate measures to ensure their computer is protected against third party interference whilst on the web.
Our site may contain links to external websites which Border Medical Oncology and Haematology adds to improve the service we offer and expand upon the information readily available to you. Once a user decides to click on a link and navigate away from Border Medical Oncology and Haematology website the privacy policy noted here is no longer in effect. Users are recommended to familiarise themselves with the privacy policies on these websites once they browse and interact with them. Recommendations or views purported on these websites are not necessarily reflective of those of Border Medical Oncology and Haematology and its associates.

Updates to this Policy
This Policy will be reviewed from time to time to take account of new laws and technology, changes to our operations and other necessary developments. Updates will be publicised on the practice's website.
Please complete the form below if you understand and agree to the following statements in relation to our use, collection, privacy and disclosure of your patient information.

I, _____ have read the information above and understand the reasons why my information must be collected, and the purposes for which my information may be used or disclosed. I understand that if my information is to be used for any purpose other than that set out above, my further consent will be obtained.
I, _____ give my permission for my personal information to be collected, used and disclosed as described above including contact via SMS to my mobile phone number and/or email to the address I've provided. I understand only my relevant personal information will be provided to allow the above actions to be undertaken and I am free to withdraw, alter or restrict my consent at any time by notifying this practice in writing.

Patient Name: _____

Signature: _____ Date: _____

Supportive Care Screening Summary & Referrals

BORDER MEDICAL ONCOLOGY

Name: _____

Phone Number: _____

Address: _____

Date of Birth: _____ Sex: Male / Female

(Place identification label here)

This page is for health professional use only

GP*: _____ Treatment plan *: _____

Diagnosis*: _____ _____

** As reported by the patient during interview*

Pain Score

Weight loss

Most important issue: (as reported by patient)

Practical Supports Required

- ☐ Transport
- ☐ Accommodation
- ☐ Home Care
- ☐ Child care
- ☐ Financial
- ☐ ADLs

Physical/emotional supports required

- ☐ Nutrition issues
- ☐ Falls
- ☐ Counselling
- ☐ Cognitive or sensory changes
- ☐ Minimal social supports

Other issues or comments:

_____

_____

_____

_____

_____

Referrals:

_____

_____

_____

_____

_____

☐ Verbal consent from patient/family to forward screening summary and/or tool on for referral purposes

Completed by: _____ Date: _____

Copies sent to:

- ☐ BMO
- ☐ Wang chemo
- ☐ MVPH chemo
- ☐ Albury chemo
- ☐ GP
- ☐ ROV
- ☐ Pall care
- ☐ Leukaemia Found
- ☐ BCN
- ☐ Other: _____

Supportive Care Screening Tool

BORDER MEDICAL ONCOLOGY

Name: _____

Phone Number: _____

Address: _____

Date of Birth: _____ Sex: Male / Female

(Place identification label here)

Please complete this page

SCREENING TOOLS FOR MEASURING DISTRESS

Instructions: First please circle the number (0-10) that best describes how much distress you have been experiencing in the past week including today.

Second, please indicate if any of the following has been a problem for you in the past week including today. Be sure to check YES or NO for each.

YES	NO	Practical Problems
☐	☐	Child care
☐	☐	Housing
☐	☐	Insurance/financial
☐	☐	Transportation
☐	☐	Work/school
☐	☐	Treatment decisions

YES	NO	Family Problems
☐	☐	Dealing with children
☐	☐	Dealing with partner
☐	☐	Ability to have children
☐	☐	Family health issues

YES	NO	Emotional Problems
☐	☐	Depression
☐	☐	Fears
☐	☐	Nervousness
☐	☐	Sadness
☐	☐	Worry
☐	☐	Loss of interest in usual activities

YES	NO	Spiritual/religious concerns
☐	☐	Spiritual/religious concerns

YES	NO	Physical Problems
☐	☐	Appearance
☐	☐	Bathing/dressing
☐	☐	Breathing
☐	☐	Changes in urination
☐	☐	Constipation
☐	☐	Diarrhea
☐	☐	Eating
☐	☐	Fatigue
☐	☐	Feeling Swollen
☐	☐	Fevers
☐	☐	Getting around
☐	☐	Indigestion
☐	☐	Memory/concentration
☐	☐	Mouth sores
☐	☐	Nausea
☐	☐	Nose dry/congested
☐	☐	Pain
☐	☐	Sexual
☐	☐	Skin dry/itchy
☐	☐	Sleep
☐	☐	Substance abuse
☐	☐	Tingling in hands/feet

Other Problems: _____

This section is for health professional use only

Medical record locations*:

☐ AWH (Alb) ☐ ROV ☐ Other: _____

☐ AWH (Wod) ☐ NHW

☐ MVPH ☐ Alb Wod Private

** Please note that this includes ALL sites where the patient has previously received, or will be receiving, treatment for cancer*

SUPPORTIVE CARE SCREENING TOOL