innervate
pain management
skills for life

Hunter Specialist Medical Centre
91 Chatham Street, Broadmeadow NSW 2292
T: (02) 4985 1869 F: (02) 49400 322
E: officemanager@innervate.com.au
W: www.innervate.com.au
ABN: 13435040866

Patient Information Sheet & Consent Form

Title: ☐ Mr ☐ Mrs ☐ Ms ☐ Miss	**Family name (surname):**	**Given name(s):**
Gender: ☐ Male ☐ Female	**Date of birth:** _ _ / _ _ / _ _ _ _	**Today's date:** _ _ / _ _ / _ _ _ _

Residential address:
Street
City/Suburb Postcode State

Contact details: Home phone Work phone
Mobile Email

Emergency Contact: Phone

How did you hear about us? ☐ GP ☐ Specialist ☐ Website ☐ Yellow pages ☐ Online ☐ Other

If WorkCover, CTP or other liability scheme, please complete the following

Date of Injury: _ _ / _ _ / _ _ _ _

Nature of Injury:

Prior to your injury were you employed? ☐ Yes ☐ No	**Occupation:**
☐ Full time ☐ Part time/ Casual ☐ Other	**Number of hours per week:**
Are you currently employed? ☐ Yes ☐ No	**Number of Hours per week:**

☐ Full time ☐ Part time/ Casual ☐ Voluntary ☐ Job left open but not working ☐ Work trial/retraining

With your pre-injury employer? ☐ Yes ☐ No

If you have a claim requiring a work Certificate of Capacity (please provide a copy of your certificate)

What is your current capacity for work?

☐ Is fit for pre-injury duties ☐ Has capacity for some type of employment ☐ No current capacity for work

Number of hours/days work per week:	Lifting/carrying capacity:
Pushing/pulling capacity:	Sitting Tolerance:
Bending/twisting/squatting:	Standing tolerance:
Driving ability:	Other:

Current Treatment Providers

Are you receiving treatment for your pain/injury? ☐ **Yes** ☐ **No**

Treatment Provider Name:

Treatment Provider Phone number:

Do you have a Rehabilitation provider? ☐ **Yes** ☐ **No**

Rehab Provider Name & Company:

Rehab Provider Phone number:

Please turn over

Please complete and sign if you understand and agree to the information provided below in relation to our use, collection, privacy and disclosure of your patient information

- I have read the information 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 including contact via SMS to my mobile phone number and/or email to the address I've provided.
- I understand that if a 3rd party (WorkCover, CTP, another liability scheme) declines my claim or refuses to pay for services provided by Innervate Pain Management, I will be held personally liable for payment of any outstanding amount.

Signed:……………………………………………….………………Date:………………………………………………

Please read this carefully

Innervate Pain Management 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 medical history so that we may properly assess, diagnose and treat you, and ensure that we are proactive in your health care.

To enable ongoing care, and in keeping with the Privacy Act 1988 and Australian Privacy Principles, we wish to provide you with sufficient information on how your personal information may be used or disclosed and record your consent or restrictions to this consent.

Your personal information will only be used for the purposes for which it was collected or as otherwise permitted by law, and we respect your right to determine how your information is used or disclosed.

The information we collect may be collected by a number of different methods and examples may include: medical test results, notes from consultations, Medicare details, data collected from observations and conversations with you, and details obtained from other health care providers (e.g. specialist correspondence).

By signing this form, you are consenting to the collection of your personal information, and that it may be used or disclosed by the practice for the following purposes:

- Administrative purposes in running our general practice.
- Billing purposes, including compliance with WorkCover and Medicare requirements.
- Follow-up reminder/recall notices for treatment and preventative healthcare.
- Disclosure to others involved in your health care, including treating doctors and specialists outside this medical practice. This may occur through referral to other doctors, or for medical tests and in the reports or results returned to us following the referrals.
- Accreditation and quality assurance activities to improve individual and community health care and practice management.
- For legal related disclosure as required by a court of law.
- For the purposes of research only where de-identified information is used.
- To allow students and staff to participate in training/teaching using only de-identified information.
- To comply with any legislative or regulatory requirements e.g. notifiable diseases.
- For use when seeking treatment by other doctors in this practice.

At all times, we are required to ensure your details are treated with the utmost confidentiality. Your records are very important and we will take all steps necessary to ensure they remain confidential.