Maaruma-Li

ABORIGINAL MEDICAL SERVICE

HEAL • FIX • MAKE BETTER

Maaruma-Li Aboriginal Corporation Aboriginal Medical Service

19 Little Timor Street, Coonabarabran NSW 2357

Email: info@maarumaliams.org.au

After Hours: 1300 153 634

02 68368500

Please let our staff know if you need assistance with filling in this form.

Contact Information			
Title: ***(Mr,Mrs,Miss,Ms)***		**First Name:**	
Surname:		**Gender:**	
Date of Birth:		**Place of Birth:**	
Street Address:			
	Suburb:		**Postcode:**
Email:		**Home Phone:**	
Work Phone:		**Mobile Phone:**	
Healthcare Identifiers			
Medicare Number:	__ __ __ __ - __ __ __ __ __ - __	**IRN:** __ **EXPIRY:** __ __ / __ __ __ __	
Pension Number:	__ __ __ - __ __ __ - __ __ __ __	**EXPIRY:** __ __ / __ __ / __ __	
Health Care Card:	__ __ __ - __ __ __ - __ __ __ __	**EXPIRY:** __ __ / __ __ / __ __	
Private Health:			
DVA	**Gold:**	**White:**	
Next of Kin			
Name:			
Contact Number:		**Relationship to you:**	
Emergency Contact Details – *(If same as 'Next of Kin' write as above)*			
Name:			
Contact Number:		**Relationship to you:**	

Cultural Identifiers *(To assist with health initiatives)* **- Are you Aboriginal and/or Torres Strait Islander?**

Yes- Aboriginal

Yes- Torres Strait Islander

Please attach your proof of Aboriginality or Elder Support Letter/Statutory Declaration

Neither *(Please specify)*

Maaruma-Li AMS services ALL people.

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Your Health Information

Allergy

Do you have any allergies or are you sensitive to drugs or dressings?

☐ Yes *(Please provide details)* _____

☐ No

☐ Unknown

Current Medications

Please list or attach copy of all your current medications, including complementary and over the counter medicines *(Homeopathic medicines such as vitamins and minerals etc.)*

_____

_____

Medical History – *(Please tick all that apply to you)*

Do you have any of the following?

Diabetes ☐ Type 1 ☐ Type 2 ☐ Gestational

☐ Asthma ☐ COPD

☐ Hypertension/Heart Disease

☐ Kidney Disease ☐ Bladder Disease ☐ Lung Disease ☐ Liver Disease

☐ Blood Borne Viruses *(e.g., Hepatitis B / C / HIV)*

☐ Cancer/s: _____

_____

☐ Other – (*Provide details*):_____

☐ Any recent Surgery or Hospital Admissions: _____

Family History Information – *(Please tick all that apply to you)*

Do any of your family members have/had any of the following?

☐ Heart Disease ☐ Asthma ☐ Diabetes ☐ Hypertension/Heart Disease

☐ Mental Illness

☐ Cancer/s – type: _____

_____

☐ Other significant – *(Provide details):* _____

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Lifestyle Risk Factor Information – *(Please tick all that apply)*

Smoking or Vape

Yes — How many cigarettes: _____ per day _____ per week

No — How many Vapes: _____ per week

Ex-Smoker — Quit Date: _____/_____/_____

Alcohol

Yes — How many standard drinks: _____ per day _____ per week

No

Recreational/Prescribed Drug Use

Yes — Type/s of Drugs? _____

No — How often: _____ daily _____ weekly _____ monthly

Disability and Mobility Information – *(Please tick all that apply)*

Disability- Physical, Intellectual, Psychosocial, Cognitive, FASD, Syndromes, Hearing, Sight, Neural & Other

Do you have a disability, injury, or long term health condition. Yes □ No □ Unsure□

Injury and Pain

□ *Chronic back or neck pain*
□ *Joint pain or arthritis*
□ *Sports injury*
□ *Work related injury*
□ *Accident or assault injury*
□ *Ongoing pain requiring management*
□ *Head injury or concussion*

Mobility and Function

□ *Difficulty walking*
□ *Uses mobility aid (cane, walker, wheelchair)*
□ *Balance problems or frequent falls*
□ *Reduced strength or endurance*
□ *Difficulty climbing stairs*
□ *Limited hand or arm function*

Neurological and Medical

□ *Stroke*
□ *Spinal injury*
□ *Nerve damage*
□ *Brain injury*
□ *Parkinson's or similar condition*
□ *Seizures /Epilepsy/ Alzheimer's*
□ *Dementia*

Mental Health & AOD (Alcohol & Other Drugs)

Opioid Use – *MS- Contin, Oxy-Contin, Targin, Panadeine forte, Endone, Tramadol, Fentanyl, Norspan,*

Benzodiazepines – *Alprazolam, Diazepam, Mogadon, Oxazepam, Nitrazepam, Xanax, etc.*

Stimulants – *Ice, Methamphetamine, Speed, Cocaine, MDMA, Ecstasy, Ritalin, Dexamphetamine*

Sedatives and Sleeping Tablets – *Zolpidem, Stilnox, Zopiclone, Imovane, Seroquel, Promethazine*

Alcohol – *Beer, Wine, Spirits, Cider, Home brew*

Cannabis – *Marijuana, Weed, Hash, Oil, Edibles*

Community Treatment Order – *Risperidone, Paliperidone, Olanzapine, Aripiprazole, Quetiapine, Clozapine, Haloperidol, Flupenthixol, Zuclopenthixol, Lithium, Valproate, Sertraline, Venlafaxine, Procyclidine, Diazepam*, Other _____

PLEASE READ THIS CONSENT FORM CAREFULLY PRIOR TO SIGNING.

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Patient Consent

Maaruma- Li Aboriginal Medical Service

We collect personal and health information to provide safe, Culturally appropriate and continuous care. Privacy Act 1988 (Cth), Australian Privacy Principles, Health Records and Information Privacy Act 2002 (NSW), My Health Records Act 2012 (Cth).

Your information may be used for:

Assessment, diagnosis treatment, care coordination, referrals, administration, billing, Medicare compliance, accreditation & quality assurance, clinical governance and service improvement, mandatory reporting including notifiable diseases, court/legal disclosures where required by law, de-identified research, workforce training, medical education, student supervision, tele-health and video consultations and referrals. We only use or disclose information where permitted by law or with your consent.

Confidentiality

All personal and health information is treated as confidential and protected through secure systems and authorised access.

Your Rights (Please tick if you agree)

You may access, correct, restrict or withdraw consent at any time by notifying the service in writing. If information is required for a new purpose, further consent will be sought.

□ I have read and understand this information
□ I consent to lawful collection, use and disclosure
□ I agree to SMS and service related contact
□ I understand my My Health Record options

Patient name: (*Please Print*) _____

Signature: _____ **Date:** _____ /_____ /_____

If not patient *– (Please Print Your Name):*

_____

Signature: _____ **Date:** _____ /_____ /_____

Your relationship to patient *- (e.g. Parent, Carer, Guardian)* _____

OFFICE USE ONLY

Witnessed by: *(Staff Signature)*

_____ **Date:** _____ /_____ /_____