

Please carefully fill in BOTH SIDES of this form prior to your child's consultation with the cardiologist

Child's Surname:	Child's First Name(s):
Address:	Date of Birth:
Private Insurance Fund:	Membership Number:
Medicare card number including reference number:	Exp Date:
Concession Card Number:	Expiry date:
Primary Carer's Name and Relationship To Patient:	DOB:
Mobile Number:	Home Phone Number:
Work Phone Number:	Email Address:
Occupation:	
Do you live in the same household as the patient?: Y N	
Medicare card number including reference number :	Exp Date:
Secondary Carer's Name and Relationship to Patient :	DOB:
Mobile number:	Home Phone Number:
Work Phone Number:	Email Address:
Occupation:	
Do you live in the same household as the patient?: Y N	
Referring Doctor:	
Usual General Practitioner:	

I, _____, give permission for any correspondence/results which will assist in my child's treatment to be sent by email to (reception@canberraheart.com.au) or fax (Fax No. 02 6162 1887) to the Canberra Heart Clinic. I also consent to my child having measurements taken and being examined by staff including the cardiologist. I have also read the privacy and access policies of this practice and agree to its contents.

Signed by primary carer: _____

Date:

NAME OF SIBLING (S)		AGE	
MEDICATION ALLERGY		REACTION	
Medical History / Relevant Family History			
CONDITION/PROCEDURE		YEAR	
MEDICATION NAME	SYRUP STRENGTH	DOSE (MILLIGRAMS)	TIMES TAKEN (Morning or Evening)
IMMUNIZATION			
Up to date : Yes No			
FEEDING INFORMATION FOR BABIES			
Feed type : Breastfeeding Formula Both		How often : hourly	
Is your baby having solids : Yes No		How often :	
Delivery : Vaginal C section			
Antenatal scans: Normal Abnormal			
If abnormal please state abnormality found:			