Canberra heart clinic

Dr Christopher Allada	Interventional Cardiologist
Dr Kris Nowakowski	Imaging Cardiologist
Dr Davinder Pal Singh	General Cardiologist
Dr Amit Michael	Interventional Cardiologist
Dr Ala Mustafa	Paediatric Cardiologist
Dr Jaydeep Mandal	General Physician

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:**

Canberra Heart Clinic: Deakin
Lidia Perin Medical Centre
Suite 1, 12 Napier Close, Deakin, ACT, 2600
reception@canberraheart.com.au www.canberraheart.com.au
Phone: (02) 6162 1886 Fax: (02) 6162 1887

Canberra Heart Clinic, Gungahlin
Marketplace Gungahlin, Big W Mall
First Floor, Suite 13, 30-33 Hibberson Street
Gungahlin, ACT, 2912
Phone: (02) 6109 7800 Fax: (02) 6162 1887

The Canberra Heart Clinic prefers to send and receive correspondence via Healthlink.

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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:

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