A/Prof Brindha Shivalingam

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Title and Name:

Pronouns:

Date of Birth:

Aboriginal: Yes / No

Torres Strait Islander: Yes / No

Next of Kin. Name, relationship and phone:

Family Doctor name and address:

Other Specialists involved in your care:

Address:

Occupation:

Phone:

Email:

Health fund and number:

Medicare number and expiry date:

DVA Number:

Pension Number:

Please note that Dr Shivalingam uses an AI scribe system for her consultation letters. If you object to this, please let us know.

Consent to Collect Information

We require you to provide us with your personal details and medical history so that we may properly assess, diagnose, treat and be proactive in your health care needs. We will use the information you provide in the following ways:

- Administrative purposes in running our clinic.
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
- Disclosure to others involved in your health care, including treating doctors and specialists outside this practice as advised by you.

I understand the reasons why my information must be collected.
I understand that I am not obliged to provide any information requested of me, but that my failure to do so might compromise the quality of health care. I am aware of my right to access the information collected about me, except in some circumstances where access might legitimately be withheld. I understand I will be given an explanation in these circumstances. I understand that if my information is to be used for any purpose other than the above, my consent will be sought. I consent to the handling of my information by this clinic for the purposes set out above.

Signature:

Date:

Fellow of the Royal Australasian College of Surgeons

Submit

Chris O'Brien Lifehouse