HAND AND UPPER LIMB SURGEON

Brisbane Hand & Upper Limb Clinic
9/259 Wickham Tce Spring Hill Q 4000
Ph/ Fax (07) 3832 3203
E reception@stevenfrederiksen.com

www.stevenfrederiksen.com

Dr Steven Frederiksen

PATIENT REGISTRATION .

Today's Date: …../…../……

Title Dr / Mr / Mrs / Miss / Ms (please circle)

Patient First name (s) ……..……Surname ……..……..……..

Address ……

……

Date of birth …… / …… / …….. Occupation ……

Home phone ……..... Work ……..…

Mobile ……. Email ……..……

Person responsible if the patient is a minor ……..……...

Medicare No …… Ref (No. next to your name) …….. Exp ..…. / …....

Private Health Insurance Fund …… Member No ……...

DVA No ……..… Gold Card / White Card (please circle)

For White card holders, please specify condition covered: ……

Pension No ……..... Expiry ……..…..……

Family Doctor's Name & Address ……....
……
……..……

I authorise Dr Frederiksen to discuss my medical condition with the person named below in the event of an emergency or if Dr Frederiksen cannot contact me directly –

Contact in case of emergency ……..……

Relationship ……..…… Phone ……..……

Is this a WorkCover Claim? YES / NO (please circle)

Employer …….. Insurance Company Name: …..……

Claim No …….. Date of injury …….. / …….. / ……..…….

MEDICAL HISTORY

What is the reason for today's appointment? ……

……

How long have you had the symptoms of this condition? ……

Do you have any current health problems? YES / NO

Please list ……..……..……..

……

Have you suffered from any serious illness in the past? YES / NO

Please list ……..……..……..

……

Please indicate (circle) if you have a history of the following:

High blood pressure	Heart problems	Lung problems
Bleeding tendency	Epilepsy	Rheumatic fever
Blood disease	Hepatitis	Diabetes
Kidney disease	Blood clots	Gastro-intestinal disorder

What operations have you had in the past? ……..……

……

Are you pregnant? YES / NO

List all your current medications (**diabetics please specify medication/dosage/time taken**)

……

……

Please list any allergies that you have ……

Do you have a **Latex** allergy? YES / NO

If yes, what reaction does this cause? ……

Do you smoke? YES / NO

If so, how much do you smoke per day? ……..… How long for? …….

Alcohol intake …….. standard drinks **per day**

Have you been tested for HIV or Hepatitis C antigen? YES / NO
If so, was the result: Positive / Negative

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CARE AGREEMENT

Patient Name: _____ DOB: _____

Thank you for attending the practice of Dr Steven Frederiksen. Your care is a joint responsibility.

During the process of care, Dr Frederiksen is responsible for providing to you, care of a standard that is widely accepted by professional peers as competent professional practice. Dr Frederiksen is obliged to warn you of the risks associated with your care that a reasonable person in your position would require to know. This information will enable you to make a reasonably informed decision to accept the advice given to you or to undergo the treatment recommended by Dr Frederiksen. Dr Frederiksen is obliged to provide you with all the information he believes you require, prior to making a decision, in regard to the recommended treatment and/or the advice provided by Dr Frederiksen.

It is your obligation to ensure you understand the treatment and advice recommended by Dr Frederiksen. It is your responsibility to ensure you ask for as much information as you require to properly understand what is proposed and to ask questions of Dr Frederiksen regarding his recommendations. This includes the risks associated with your treatment and any other treatment options available to you. You are required to understand all aspects of your treatment and care, to ensure you make a fully informed decision regarding the treatment of your choice.

It is your obligation to take an active role in the management of your treatment and care. You are obliged to obtain therapy and related treatments prescribed by Dr Frederiksen and to follow all instructions referring to your care, treatment or therapy carefully. This includes but is not limited to all pre-operative and post-operative instructions.

It is your obligation to attend the appointments scheduled for you with Dr Frederiksen. If you cannot attend these appointments you must advise Dr Frederiksen's practice at least 24 hours prior to the scheduled appointment. It is your obligation to pay accounts for consultations with Dr Frederiksen at the time of consultation and prior to the date of surgery, where required.

It is the joint responsibility of both you and Dr Frederiksen to treat each other with courtesy and respect.

"Please note this practice expects all parties to refrain from unacceptable or disruptive behaviour that poses a threat to the rights or safety of other patients and staff."
AMAQ Patient Code of Conduct.

Should you have any concerns in respect to your care, please do not hesitate to contact Dr Frederiksen or any member of his staff.

_____ _____
Signature of Patient/Parent/Guardian/Other Specify Other [PLEASE PRINT]

Date: _____

UPPERLIMB.COM
BRISBANE HAND & UPPER LIMB CLINIC

DR **STEVEN FREDERIKSEN**
ORTHOPAEDIC SURGEON
Surgery of the Hand & Upper Limb
MBBS FRACS FAOrthA CIME
Provider No. 225328PB

CONSENT FOR DISCLOSURE

Patient Name: _____ DOB: _____

I consent to the following:

- Receipt of text messages from this practice to the nominated mobile number.
- Receipt of voicemail messages from this practice on the nominated landline and/or mobile number.
- Clinical images to be used for purposes including clinical discussion, training and education.
- Electronic transmission of information regarding my appointments and/ or condition between this practice and myself, or to other healthcare providers, allied health/rehabilitation providers.
- Discussion regarding my appointments and/ or condition with the people listed below:

  Name: _____ Relationship: _____

  Name: _____ Relationship: _____
- This practice communicating with WorkCover Queensland and its relevant agents, other relevant insurers, employers and allied health/rehabilitation providers regarding my medical history and treatment relevant to this claim.
- This practice using AI medical scribe.

I acknowledge that I am responsible for notifying this practice of any changes to the above.

_____ _____

Signature of Patient/Parent/Guardian/Other Specify Other [PLEASE PRINT]

Date: _____

Level 3, Brisbane Private Hospital, 259 Wickham Terrace, Brisbane Qld 4000
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FAORTHA FELLOW of the AUSTRALIAN ORTHOPAEDIC ASSOCIATION FRACS