

To enable us to organise an appropriate appointment for you we ask that you complete the enclosed Patient Detail Questionnaire and return to our office as soon as possible. If not previously forwarded, please include the following:

- GP Referral
- X-Ray or Scan Reports (Films are not required at this point)

The above forms can be either mailed, faxed or emailed.

Current address: Dr John Albietz
Level 10 Suite 14
Evan Thomson Building
24 Chasely Street Auchenflower 4066

Fax: 07 3721 8666

Email: admin@qcos.net.au

The information received will be reviewed by Dr John Albietz and we will contact you by mail within 5 working days with an appointment date and time.

Thank you for your understanding and co-operation.

DATE: ___/___/___

RL

Title: Mrs Miss Ms Mr Mast Dr

Family Name: _____ Given Name: _____

Address: _____

Date of Birth: ___/___/___

Ph: (h) _____ (w) _____ Mobile _____

Medicare No: Exp: _____

Medicare Reference Number (Small Number in front of your name):

Dept. Of Veteran Affairs No: _____ Exp: ___/___/___ Gold Card / White Card

Health Care Card / Pension No: _____ Exp: ___/___/___

Are you a member of a Private Health Fund: Yes / No

Health Fund: _____ Membership No: _____

Level of Cover (Please tick): Full Private Hospital Extras Only

ACCOUNT PAYMENT DETAILS

Self

Workcover Claim No: _____

Company/Employer _____

Other Details: _____

REFERRAL DETAILS

Referring Doctor Name: _____

Address: _____

Usual GP (If different from referring doctor) _____

Address: _____

NEXT OF KIN DETAILS

Next of Kin: _____ (Relationship) _____

Address: _____

Phone: _____

PATIENT CONSENT

I give permission for you to disclose to any doctor, health authority, allied health provider, rehabilitation provider, Workcover Insurer and its agents, or other insurer any information about my medical history relevant to my treatment.

Signature: _____ Date: _____

X-RAYS

The QCOS Orthopaedic does not store x-rays / scans for any period of time exceeding twelve months. It is essential that you keep the scans in your possession at all times.

I hereby understand that the QCOS Orthopaedic will destroy any x-rays or scans left in their possession after twelve months, without prior notice.

Signature: _____ Date: _____

Patient Name: _____ DOB: _____

Do you have a current legal claim regarding this condition? Yes No

Are you seeing a Solicitor for this condition? Yes No

Will you need a legal report? Yes No

Is your problem: Scoliosis Other

If other, please give details: _____
