

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 Simon Gatehouse  
Level 10 Suite 14  
Evan Thomson Building  
24 Chasely Street Auchenflower 4066

Fax: 07 3721 8666

Email: [admin@qcos.net.au](mailto:admin@qcos.net.au)

The information received will be reviewed by Dr Simon Gatehouse 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: \_\_\_\_\_

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**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: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_