MR LACHLAN BATTY
Specialist Orthopaedic Surgeon

Epworth Hospital, Suite 8.1, Level 8
89 Bridge Rd Richmond VIC 3121
Ph (03) 8763 5633 Fax (03) 7035 0173
contact@lachlanbatty.com.au
www.lachlanbatty.com.au

Patient Registration Form *Please complete all fields.*

Date of appointment: _____

Title: Mr / Mrs / Miss / Ms / Dr Surname: _____

Given Names: _____ Preferred Name: _____

Mobile Phone: _____ Home Phone: _____ Date of Birth: _____

Email: _____

Address: _____

City: _____ State: _____ Postcode: _____

Occupation: _____ For shoulder conditions - right or left handed *(please tick):* Right ☐ Left ☐

Emergency Contact / Guardian (for minors) Full Name: _____

Phone Number: _____ Alternate Phone Number: _____

Relationship to Patient: _____

General Practitioner Full Name: _____ Phone Number: _____

Address: _____

City: _____ State: _____ Postcode: _____

Do you have a regular Physiotherapist? Full Name: _____ Phone Number: _____

Address: _____

City: _____ State: _____ Postcode: _____

Medicare Card No. _____ Ref No. *(number in front of patient's name):* _____ Expiry: _____

Private Health Insurance: Y / N Fund Name: _____ Member no. _____

Have you served the waiting period on your Health Fund? Y / N Do you have an excess to pay on your Health Fund? Y / N

Pension no. *(Blue pension card only - NOT healthcare card):* _____ Expiry: _____

Dept Veteran's Affairs: Gold / White Card no. _____

Worksafe or TAC no. _____ *(Please bring relevant paper work.)*

WorkCover insurer: _____ Date of Workplace Injury: _____

Case Manager Name: _____ Phone Number: _____

Referral Source: GP / Specialist / Physio / Other: _____

Referring Doctor's Name: _____

Referring Doctor's Address: _____

City: _____ State: _____ Postcode: _____

Provider No. _____ Phone Number: _____ Email: _____

Past Medical History *Please complete all fields.*

Height in cm *(approximate if unknown):* Weight in kg *(approximate if unknown):*

Are you currently a smoker? Y / N Number of cigarettes per day:

Do you regularly drink Alcohol? Y / N Standard drinks per day

Do you have Diabetes? Y / N If yes, treated with *(please tick):* Diet ☐ Tablets ☐ Insulin Injections ☐

Medications Screening

Anticoagulants (blood thinners) ☐ Imunosuppressants ☐ Steroids (i.e Cortisone) ☐ Pain medications ☐

Please list your current medications: _____

_____

_____

Allergy Screening *Please tick below if you are allergic to any of the following:*

Surgical Preparations (iodine, chlorhexidine, betadine) ☐ Tapes/dressings ☐ Latex ☐ Antibiotics ☐

Other Allergies: _____

_____

_____

Anaesthetic Screening

Have you experienced any issues with previous anaesthetics? Y / N Any nausea & vomiting after anaesthetic? Y / N

Intubation Issues? Y / N Spinal Surgery? Y / N Malignant Hyperthermia (or family history of)? Y / N

Please give details: _____

_____

_____

Medical Conditions *Please tick the condition below if relevent to your medical history:*

Endocrine Conditions:

Thyroid Disorder ☐

Cardiovascular Conditions:

Heart Attack ☐ Stroke ☐

Haematological Conditions:

DVT (Blood clot in leg) ☐

PE (Blood clot in lung) ☐

Respiratory Conditions:

Asthma ☐ COPD ☐

Bronchiectasis ☐

Neurological Conditions:

Parkinson's ☐

Renal Conditions:

Kidney Failure ☐

Liver Conditions:

Liver Failure ☐ Cirrhosis ☐

Infectious Diseases:

Hepatitis B ☐ Hepatitis C ☐

HIV/AIDS ☐

Cancer: Y / N

Type of Cancer: _____

Previous Surgical History

Please outline any previous surgery you have had below:

_____

_____

_____

_____

MR LACHLAN BATTY
Specialist Orthopaedic Surgeon

Epworth Hospital, Suite 8.1, Level 8
89 Bridge Rd Richmond VIC 3121
Ph (03) 8763 5633 Fax (03) 7035 0173
contact@lachlanbatty.com.au
www.lachlanbatty.com.au

Patient Consent

I consent for SMS appointment communication *(please cirle):* Y / N

I consent for video/photography to be taken *(please cirle):* Y / N

If you consent to photographs being taken of you by Mr Lachlan Batty, please give written consent below:

I, _____ hereby consent to video/photography of me being taken by Mr Lachlan Batty.

Mr Lachlan Batty at all times respects patients' right to privacy and informed consent for procedures within the Practice, including photographic records. I understand that these photographs form an essential part of my medical record as well as my pre-operative and post-operative assessment. I understand and consent to my photographs being used by Mr Lachlan Batty for medical research, teaching and/or patient education purposes. I understand that I will not be identified by name in any such use of these photographs, however, in some circumstances the photographs may portray features that could make my identity recognisable.

Signature: _____ Date: _____

Health Records Act

Dr Lachlan Batty is collecting your health information in order to provide you with health services. Please read and sign to give approval for this information to be collected and stored. Your medical information will be used exclusively for providing health care in the following way:

- To gain a history, diagnose disease and provide treatment where necessary;
- Administrative purposes in running this Practice, which may also include confirmation of your appointment.
- Writing reports to your Doctor, other Doctors and/or Allied Health care providers involved in the provision of healthcare, and the storing of reports provided to this Practice by other Doctors or Medical Specialists; and
- Billing and collection purposes, including but not limited to compliance with Private Health Fund, Medicare and Health Insurance Commission requirements. You may gain access to your health information by writing to us. If you do not consent to providing us with your health information we may be unable to provide you with health services.

☐ I consent to Mr Lachlan Batty collecting my health information.

☐ I consent to Mr Lachlan Batty Practice communicating with me, my 'emergency contact' and my 'contact person' via the above provided email address, phone numbers and/or mailing address, including receiving confidential clinical correspondence. I give permission for Mr Lachlan Batty or his staff to contact me by email, SMS, mail and/or telephone & if necessary leave a message.

☐ I have read all of the above and all my questions have been answered.

Signature: _____ Date: _____

How did you hear about Mr Lachlan Batty? *(Please tick)*

RACS Website ☐ AOA Website ☐ Personal Recommendation ☐ Google ☐

Epworth Website ☐ OSV Website ☐ www.lachlanbatty.com.au ☐ Referring Doctor ☐