A/Prof Thomas Lee

Consultant Gastroenterologist
Inflammatory Bowel Disease Specialist
Clinical Assoc Professor University of Wollongong

Seaview Clinic
Suite 701, Level 7
360-364 Crown Street Wollongong NSW 2500
Email: info@seaviewclinic.com.au

Ph: 02 42107870
Fax: 02 42271502

Gastroenterology - Patient information Package

Surname: Mr/Mrs/Ms/Miss/Other________________________________

First Name:____________________ **Middle Name: -**________________

Preferred Name: ________________________ **DOB:** ______________

Postal Address: ____

Suburb: ____________________ **State:**________ **Postcode:**_______

Preferred Contact Number:________________ **2nd Contact:**_____________

Email:____

Occupation (Including Previous Occupation):__________________________

Medicare Number:____________________ **Ref No:**_____ **Expiry:**________

Pension Number:________________ **Private Health Fund: Yes/No - If yes,**

Fund Name:____________________ **Membership Number:**_______________

Veterans' Affairs: Yes/No - if yes, Card Colour: ________ **Membership Number:**_______

Are you: Aboriginal: Yes/No________ **Torres Strait Islander: Yes/No**____________

Country of birth: ____

Is an Interpretor Required: Yes/No **Language Spoken:**__________________

Next of Kin:____________________ **Relationship:**____________________

Postal address (if different from above):____________________________

Suburb:____________________ **State:**__________ **Postcode:**_______

Preferred Contact Number:______________ **2nd Contact Number:**____________

Do you consent to your GP receiving ongoing treatment information: Yes/No

GP's Name:____________________ **Phone Number:**_________________

Address:____

Height:____________________Weight:________________________

Current Medications:

Medication Name	Dosage	Frequency

Do you take any blood thinning medication? Yes/No___________________________________

Allergies:____

Family Medical History: (please circle)

Heart Disease   High Blood Pressure   Respiratory Disease

Diabetes   Colon Polyps   Cancer

Past Medical History:

Year of last Gastroscopy:____________________Year of last Colonoscopy:__________________

Do you smoke now? Yes/No   How many cigarettes per day?

How many years have you been smoking?

Have you ever smoked? Yes/No   How many cigarettes per day?

For how many years did you smoke?

When did you stop smoking?

Do you drink alcohol? Yes/No   How many drinks per day?

How many drinks per week?

Reason for Consultation:____

____

____

Consent to Release Medical Information

To Whom It May Concern,

I, ____

(Insert name of person consenting to release of information)

Of____

(Insert Address details)

Date of Birth: ____

Hereby give permission for Dr Thomas Lee to:

* Have access to medical results, information and/or specimens necessary for the management of my medical condition/s.

* Release my medical information to other health professionals exclusively for the ongoing management of my medical condition/s. This includes: medical specialist forums called "Multidisciplinary Team" (MDT) meetings which occur at regular intervals.

* Use the (de-idenfitied) information in my medical file for the purpose of teaching, quality assurance reviews and for research purposes.

Dr Thomas Lee acknowledges all obligations regarding patient confidentiality as stated in The Privacy Act 1988 and The Privacy Amendement (Private Sector) Act 2000.

Signature:____

Date:____