PASO

PATIENT DETAILS

Title: _____ Surname: _____ Given name: _____

Date Of Birth: _____ Email: _____

Address: _____

Phone: _____ Mobile: _____ Occupation: _____

Gender (Please specify): _____ ☐ **I prefer not to say**

Marital Status (Please Tick): **Single** **Married** **Divorced** **Seperated** **Widowed** **De-Facto** **Other**

Are you of Aboriginal and/or Torres Strait Islander Descent? _____

EMERGENCY CONTACT DETAILS

Name: _____ Relationship: _____ Phone: _____

MEDICARE INFORMATION AND PRIVATE HEALTH COVER

Medicare No. _____ Reference No. _____ Expiry Date: _____

Do you have Private Health Cover? (Please Circle) YES NO

Name Of Fund: _____ Member No. _____ Reference No. _____

REFERRAL

Ferinject 500 Ferinject 1000 Other: _____

HB (Attach Report, Must be within 4 weeks): _____

Ferritin (Attach Report, Must be within 4 Weeks): _____

Other: _____ Known Allergies: _____

Pregnant (Please circle) YES NO

Relevant Medications (Or Attach List): _____

Previous Reaction to Iron (Please circle) YES NO

REQUESTING DOCTOR DETAILS

Doctor Name: _____

Provider Number: _____ Phone: _____

Practice Name and Address: _____

_____

I understand that PASO Medical complies with the privacy and data protection act 2014 and as part of their privacy policy they are committed to protecting the privacy of individuals and their personal information. My signature below indicates that I have read the above and consent to PASO Medical collecting, using, storing and disposing of my personal information; the release of relevant personal information to other health professionals to allow quality medical care; inclusion in a recall register to be advised of follow up visits: inclusion in national/state reminder systems / registers, medical updates and health information and the release of relevant personal information to my (prospective) employer, their authorized representative and their insurer in the case of a work related consultation or service. I understand that I may request access to my personal information which may be granted in accordance with the Practice's Access to Personal Information Policy. I will be provided a written reason if access is denied. I understand that I may request an amendment to my personal information if it is incorrect. I will be provided with a written reason if a request for amendment is denied. I understand that my personal information will not be used for direct marketing or disclosed to overseas recipients. I understand I may withdraw my consent to PASO Medical to use and disclose my personal information (except when legal obligations must be met). I understand that I am not obliged to provide the Practice with my personal information, but withholding information may limit the Practice's ability to provide me with full service. I hereby authorise PASO Medical to access any relevant medical information required from other hospitals or medicare providers. I understand that I have a right to lodge a complaint about the handling of my personal information if I am dissatisfied which will be dealt with in accordance with the Practice's Complaint handling procedure.

Signature: _____ Date: _____

*NOTE: **Please email all referrals to infusions@paso.com.au** | If you see the doctor on a day you have been admitted to Hospital for treatment, you are classed as an inpatient and we will automatically send your account through to your private health fund. If however on the day you see the doctor your treatment is not scheduled or you are currently not having any treatment as an inpatient, the cost of the consultation is payable by you, with a rebate available from Medicare. If you have any questions regarding the above, please speak to a receptionist.*

IRON INFUSION SERVICE REQUEST FORM