HealthWISE
Creating healthier communities

Aboriginal Health Services
Client Registration and Consent Form

Is the Client either Aboriginal, Torres Strait Islander or both? ☐ Yes ☐ No

Client's first name _____ **Client's last name** _____

Known as any other name? _____

Address _____ **Town** _____ **Post Code** _____

Home phone _____ **Work phone** _____ **Mobile** _____

DOB ___ / ___ / ___ **Current age** ___ If patient is under the age of 16, Parent/Guardian permission must be given

Usual medical practice _____ **Preferred doctor** _____

Emergency Contact: Name _____ **Phone** _____

- This form registers an individual(s) to become a member client of HealthWISE New England North West Health Access Services.
- Registration will entitle the member client to access services within the HealthWISE New England North West Health guidelines which can include but are not limited to:
  - assistance to access health services;
  - assistance with transport to health related appointments;
  - assistance to access specialist appointments/treatment;
  - information and assistance to access available health programs etc.
- All information shared between the member client and HealthWISE New England North West Health will be treated as strictly confidential at all times.

At any stage the member client can request to be removed from the service.

I, (or my child/ward) Client's full name _____

Agree to my (or my child/ward's) records being kept in the computer database of HealthWISE. I acknowledge that the purpose of the database is to assist in the management of health checks and possible health condition/s and to establish health outcome goals in the community.

I understand that all results relating to my (or my child/ward's) health checks and/or health condition/s may be accessible to Health Service providers involved in my (or my child/ward's) care.

This consent is subject to:

- The information on the database being kept strictly confidential;
- Any information required for research being used on de-identified data reports;
- My right to withdraw consent at any time by completing a withdrawal form requesting my file be destroyed.
- My Medical History and diagnosis being discussed with my GP and other health professionals involved in my care.

I, (full name) _____ have read and understood the above Consent Form.

I agree to these conditions for the service provided by HealthWISE for myself, OR *child's name:* _____

Signature _____ Date ___ / ___ / ___

OR

I, (health professional's name) _____ have informed client's name: _____ of the conditions of the HealthWISE service.

The client has given verbal consent to these conditions and for HealthWISE to provide services to them or *child's name*: _____

Signature _____ Date ___ / ___ / ___

STAFF ONLY *Date entered* ___ / ___ / ___ *Staff Member* _____

QIC Quality Innovation Performance ACCREDITED
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Client Intake Form - Aboriginal Health Services

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Client Information

Are you Registered on PBS Co-Payment (CTG Scripts) ☐ Yes ☐ No*

MBS Item 715 Completed ☐ Yes ☐ No*

*If no for either or both of these questions discuss with the client how these initiatives may assist their Health outcomes.

Height _____ cm **Weight** _____ kg

Smoker ☐ Yes ☐ No* *Have you ever smoked? ☐ Yes ☐ No

Drinker ☐ Yes* ☐ No *If yes, how many Alcoholic drinks per week? _____

*If yes, what year did you start? _____

Ex-Drinker ☐ Yes* ☐ No *If yes, what was your past alcohol intake? ☐ Occasional ☐ Moderate ☐ Heavy

*If yes, what year did you start? Year stopped? _____

STAFF - Refer to CAGE Questions on Best Practice.

Chronic Condition ☐ Yes* ☐ No

Diabetes Type II ☐ CVD ☐ COPD ☐ Other _____

**If yes, please complete an Integrated Team Care Client Referral & Consent Form and forward to closest Care Coordinator as listed on form for follow up.*

Immunisation - For Clients 50 years of age and older

Influenza ☐ *Yes ☐ No *Date __/__/____ Pneumococcus ☐ *Yes ☐ No *Date __/__/____

COVID-19 ☐ *Yes ☐ No *Date __/__/____

Immunisation - For children 5yrs and under - Refer to child's Blue Book

Immunisation Update C-5 Schedule

Birth	Date __/__/____	(HB Vax II)
6-8 Weeks	Date __/__/____	(Rotarix, Intanrix hexa, Prevenar 13)
4 Months	Date __/__/____	(Rotarix, Intanrix hexa, Prevenar 13)
6 Months	Date __/__/____	(Rotarix, Intanrix hexa, Prevenar 13)
12 Months	Date __/__/____	(Mentorix, MMRII/ PRIORIX)
18 Months	Date __/__/____	(Priorix-textra)
3.5 - 4 Years	Date __/__/____	(Infanrix IPV, MMRII/PRIORIX)

Pregnancy

☐ Yes* ☐ No

*If yes, how many weeks are you? _____

*When did you first present to the Doctor?

_____

If you don't have the answers for any of the questions at the time of completing this form, a staff member from HealthWISE will contact you or your Health Provider for these details.

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