

ABORIGINAL HEALTH SERVICES

Client Registration and Consent Form

Is the client Aboriginal? Yes No **Is the client Torres Strait Islander?** Yes No

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

Known by 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 below.

Usual medical practice **Preferred doctor**

Emergency contact name **Phone**

- This form registers an individual to become a client of HealthWISE health access services.
- Registration will give the client access to HealthWISE services, which can include but are not limited to:
 - assistance accessing health services;
 - assistance with transport to health related appointments;
 - assistance accessing specialist appointments/treatment;
 - information and assistance to accessing health programs.
- All information shared between the member client and HealthWISE will remain strictly confidential at all times.

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

I, (full name) agree for my records, or give consent for my
child/ward 's records, to be kept in the HealthWISE computer
database. I acknowledge that the purpose of this database is to manage health checks or conditions and work towards community
health goals. I understand that this information may be accessible to health 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 used for research being taken from de-identified data reports;
- My right to withdraw consent at any time, subject to the provision of a written request to iahp.staff@healthwise.org.au;
- 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 USE ONLY Date / / Staff Member

ABORIGINAL HEALTH SERVICES

Client Intake Form

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	Blood Pressure	mmHg
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
			*If yes, what year did you start?	Year stopped?	Heavy

STAFF - Refer to CAGE Questions on Best Practice.

Chronic Condition Yes* No *Please check all that apply*

Diabetes Type II	Cardiovascular disease (CVD)	Respiratory disease	Cancer
Kidney disease	Mental health condition	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. An up to date General Practice Management Plan (GPMP) will be required. 3 weeks notice is essential if travel/accommodation is needed.

Mental Health Condition Yes* No

*If yes, please complete an **Indigenous Mental Health Client Referral & Consent Form** and forward to closest team member as listed on form for follow up. Please note, this service is only available in selected areas. Please see form for more details.

Immunisation - for clients 50 years of age and older

If 'yes', please include date of immunisation.

Influenza	Yes	No	Date	/	/
Pneumococcus	Yes	No	Date	/	/
COVID-19	Yes	No			
Number of doses					
Last vaccine (date)	/	/			

Immunisation For children 16 years and under

Immunisation up to date

Yes No Unsure

Please attach a copy of child's blue book or immunisation history statement.

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 HealthWISE staff member will contact you or your health provider for these details.