INDIGENOUS AUSTRALIAN HEALTH PROGRAM
Client Registration and Consent Form

HealthWISE
Creating healthier communities

Version 2: Updated July 2024

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

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

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

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

DOB ____ / ____ / _____ **Current age** _____

Medicare no. _____ **Concession Card no.** _____

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 professionals 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 _____

HEAD OFFICE:
213 Peel Street
Tamworth
NSW 2340

HealthWISE
T: 02 6766 1394 **F:** 02 6766 1372
E: iahp@healthwise.org.au
W: www.healthwise.org.au

INDIGENOUS AUSTRALIAN HEALTH PROGRAM
Client Intake Form

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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 ☐ Heavy

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

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.

QIC Quality Innovation Performance ACCREDITED
ABN 48 603 486 442

phn HUNTER NEW ENGLAND AND CENTRAL COAST
An Australian Government Initiative

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