PAEDSWEST
99 Central Ave Mount Lawley WA 6050

CONFIDENTIAL INFORMATION SHEET

PATIENT'S DETAILS ENTER BELOW

(Given/1st Name) (SURNAME/Family Name) (Date of Birth)

RESIDENTIAL ADDRESS

Postcode

POSTAL ADDRESS
(IF SAME WRITE A/A)

Postcode

REFERRING DOCTOR's NAME

PROVIDER No: **Date of Referral:**

Practice Name & Address:

Phone: Fax:

FAMILY DOCTOR / GENERAL PRACTITIONER
(If different from referring doctor)

Practice Name:

Address:

Phone:

MEDICARE NUMBER ☐☐☐☐ ☐☐☐☐☐ ☐

Number next to patient name ☐ **VALID TO** **/20**

PRIVATE HEALTH INSURANCE **Y/N** If yes, name of Fund
Membership No:

PLEASE TURN OVER AND COMPLETE OTHER SIDE OF FORM.

PATIENT EARLY HISTORY

Where patient born WHICH Country? IF AUSTRALIA WHICH STATE:

How many weeks gestation? (Weeks) (Days) BIRTH WEIGHT: Were there complications during the PREGNANCY?

Were there complications during DELIVERY?

Were there complications during the NEWBORN period?

Is there any DIAGNOSED medical condition in the child or family? (Please state when diagnosed and what medication if any for each condition)

Epilepsy/Seizure Patient Y/N Mother Y/N Father Y/N Other? Who?

Migraine/Headache Patient Y/N Mother Y/N Father Y/N Other? Who?

Learning Difficulties Patient Y/N Mother Y/N Father Y/N Other? Who?

Muscle Disorders Patient Y/N Mother Y/N Father Y/N Other? Who?

Sleeping Problems Patient Y/N Mother Y/N Father Y/N Other? Who?

Developmental Delay Patient Y/N Mother Y/N Father Y/N Other? Who?

ADD/ADHD Patient Y/N Mother Y/N Father Y/N Other? Who?

Diabetes Patient Y/N Mother Y/N Father Y/N Other? Who?

Allergies Patient Y/N Mother Y/N Father Y/N Other? Who?

Breathing Patient Y/N Mother Y/N Father Y/N Other? Who?

Cardiac/Heart **Patient Y/N** **Mother Y/N** **Father Y/N** **Other? Who?**

Behaviour Issues **Patient Y/N** **Mother Y/N** **Father Y/N** **Other? Who?**

ANY OTHER **Patient Y/N** **Mother Y/N** **Father Y/N** **Other? Who?**

ANY MEDICATIONS not mentioned above FOR ANY OTHER REASONS

ANY VITAMINS/MINERALS/SUPPLEMENTS

PLEASE COMPLETE NEXT PAGE

PATIENT MOTHER'S/GUARDIAN NAME **Home ☎**

Mobile ☎

Address

Mth's Date of birth Occupation Work ☎

EMAIL:

Preferred method of contact:

PATIENT FATHER'S/GUARDIAN NAME **Home ☎**

Mobile ☎

Address

Fth's Date of birth Occupation **Work ☎**

EMAIL:

Preferred method of contact:

PATIENT SIBLINGS (Please list names and dates of birth)

PLEASE ADD ANY OTHER INFORMATION HERE