

Please complete and return this form to the facility as soon as you are able.

Patient's title:		Surname:		First name:		D.O.B.	
Facility name:					Telephone :		
Address:					Fax :		
Next of kin:			Relationship:		Telephone:		
Address:					Mobile :		
If DVA Gold Card Holder:		DVA Card No: VX					
If Financial Member of State Trustees:		Liaison Person Name and Contact Number:					
If Medicare Australia:		Medicare No:		Exp Date:			
G.P. name :					Telephone:		
Address :					Fax:		
Patient Medical History (list or supply photocopy of CMA)							
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SPECIFICALLY , is there a history of any of the following? Please tick ALL that are relevant.							
Cardiac related:			Other:				
<input type="checkbox"/> valve disease			<input type="checkbox"/> Joint replacement – please specify				
<input type="checkbox"/> Previous surgery			<input type="checkbox"/> Osteoporosis/other bone disease			<input type="checkbox"/> Speech/Swallowing problems	
<input type="checkbox"/> pacemaker			<input type="checkbox"/> Diabetes			<input type="checkbox"/> HIV/Hepatitis	
<input type="checkbox"/> rheumatic fever			<input type="checkbox"/> Excessive Bleeding			<input type="checkbox"/> Mental Illness	
<input type="checkbox"/> congenital heart disease			<input type="checkbox"/> Dementia/Alzheimer's				
<input type="checkbox"/> heart murmur			<input type="checkbox"/> Aggressive Behaviour				
Please list all known ALLERGIES.							
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