BRISBANE BONE & JOINT CLINIC

DR LORENZO CALABRO
MBBS (Hons 1), BPhty, FRACS, M Eng, FAOrthA
Orthopaedic Surgeon
Hip, Knee & Trauma Specialist
ABN: 70 182 844 825 | Provider No: 409944RH

Dear

APPOINTMENT CONFIRMATION

We are pleased to confirm that an appointment has been made for you to see Dr Lorenzo Calabro on_____ at_____ at the following location:

DR LORENZO CALABRO
Brisbane Bone & Joint Clinic
Brisbane Private Hospital
259 Wickham Terrace
Ground Level, MAIN FOYER
SPRING HILL QLD 4000

Please bring along a current referral as well as any recent results of tests or scans for Dr Calabro to review.

PRIVATE FEES

New/ Initial Consultations	**$260.00**	**($84.15 Medicare Rebate)**
Subsequent Consultations	**$100.00**	**($42.30 Medicare Rebate)**

We are pleased to be able to offer online Medicare claiming.

Enclosed with this letter are "Patient Information" and "Privacy Policy" forms. ***Please take the time to complete these and either scan and email back to reception@drcalabro.com.au, fax to 07 3319 6987 or return by mail along with your GP / Specialist referral***

We look forward to seeing you on the day of your appointment and if you have any queries or concerns in the lead up, please don't hesitate to give us a call in the rooms on (07) 3193 3382.

Kind regards

Marie Stevenson
Practice Manager for
Dr Lorenzo Calabro

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PATIENT INFORMATION FORM

SURNAME:_____**FIRST NAME:** _____

TITLE: (please circle) **MR MISS MRS MS** **DOB:**_____

ADDRESS:_____

SUBURB: _____**STATE**: _____ **POSTCODE:** _____

HOME: ( ) _____ **WORK:** ( ) _____ **MOB:** ( ) _____

EMAIL: _____

MEDICARE NO: _____ **PREFIX:** _____ **EXP DATE:** _____/_____

VET AFFAIRS: (please circle) **YES** **NO** **VET AFFAIRS NO:** _____

NAME OF HEALTHFUND: _____ **MEMBERSHIP NO:** _____

Have you served your 12 month waiting period: (please circle) **YES** **NO**

DEFENCE NUMBER (DAN & PM Keys):_____

WORKCOVER / THIRD PARTY: (please circle) **YES** **NO**

EMPLOYER: _____ **CLAIM NO:** _____

Case Manager: Name _____ **Phone:** _____

OCCUPATION:_____ **DUTIES:**_____

NEXT OF KIN:

NAME: _____ **RELATIONSHIP:** _____

HOME: ( ) _____ **WORK:** ( ) _____ **MOB:** ( ) _____

GENERAL PRACTITIONER

GP NAME: _____ **PRACTICE NAME:** _____

ADDRESS: _____

MEDICAL HISTORY:

Please list any recent surgery / Medical conditions:

_____

Please list your current Medication:

_____

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PRIVACY POLICY

Due to the Federal Privacy Act 1988, we require your written consent to collect personal information about you. Please read this information carefully and sign where indicated below.

We require you to provide us with your personal details and a full medical history so that we may properly assess, diagnose and treat you. We may need to collect information from previous doctors, health care workers, pathology or x-ray services that you have consulted with, for the primary purpose of providing quality health care. This means that we will use the information you provide in the following ways:

- *Best assess your health care needs and provide medical treatment.*
- *Administration purposes in running our practice. We may need to contact you using phone numbers provided by you.*
- *Billing purposes and debt collection, including compliance with Medicare and Health Insurance Commission requirements.*
- *Disclosure to others involved in your care, including treating doctors, specialists and hospital booking staff outside this practice. This may occur through referral to other doctors, surgery at hospitals, for medical tests and in the reports or results returned to us following the referrals.*
- *Collection of data for research purposes. This information is used to improve our treatment protocols, which will enable us to improve our quality of care. The data is kept in a secure manner and only staff involved in the research has access to them. You may be contacted at some time in the future for follow up purposes. No information that can be used to identify you will be included in any publication of the research results. You may withdraw from the research at any time.*
- *You may be contacted for follow up in the future to ensure the long term results of your procedure.*

You have the right to see any health information we hold about you as well as the ability to correct any details that are not accurate.

FULL NAME: **DATE OF BIRTH:**

ADDRESS:

I have read the above information and voluntarily give my consent

.....

SIGNATURE OF PARENT / GUARDIAN: **DATE:** ___/___/___