NSW GOVERNMENT Health
South Eastern Sydney Local Health District
Illawarra Shoalhaven Local Health District

Facility:

HEREDITARY CANCER CLINIC REGISTRATION FORM

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. ____/____/____	M.O.
ADDRESS	
LOCATION / WARD	
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE	

Date & Time _____

Genetic File #_____

SEI005110

Holes Punched as per AS2828.1: 2012

BINDING MARGIN - NO WRITING

Identification details

Family name _____ Given name(s) _____

Address _____ Home phone _____

Suburb _____ Post code _____ Work phone _____

Date of Birth _____ Sex _____ Mobile phone _____

Country of Birth _____ Email _____

Medicare no _____ Line no _____ Expiry ____ / ____

Health Insurance Fund _____ Policy number _____

Jewish Ancestry: ☐ Y ☐ N

Language spoken at home _____ Interpreter: ☐ Y ☐ N Aboriginal/Torres Strait: ☐ Y ☐ N

Patient's Next of Kin or Contact

Family name _____ Given name(s) _____

Address _____ Phone _____

Suburb _____ Post code _____ Relationship to patient _____

Family/Referring Doctor Details

Referring doctor _____ Phone _____

Address _____

Family GP _____ Phone _____

Address _____

Have you or any of your family members previously attended a hereditary cancer service? ☐ Y ☐ N

The Hereditary Cancer Clinic has a computerised patient care system. The information stored includes the above registration details and may include information on your diagnosis, medical history, family history, clinic visits and test results.

This information is primarily used to ensure high quality management of your care in this department. Your information may also be used for statistics, quality assurance studies and research to better understand health outcomes in our patients. No identifying data will be released or made public when used for these purposes. Please indicate here if you do NOT want your unidentified information used for research.

Your health care data is accessed only by authorised health care professionals who are bound by a duty of confidentiality. Information about your health will only be released to health care professionals outside of this department if this is important for your care (for example your family doctor) or is required or authorised by law.

I understand and consent to the above:

_____ _____

Signature of patient *Date*

HEREDITARY CANCER CLINIC REGISTRATION FORM

SEI005.110

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NO WRITING