Sleep & Lung Care
RESPIRATORY & SLEEP PHYSICIANS
Phone (03) 9422 0077 · Fax (03) 9454 9339
reception@sleepandlungcare.com.au · sleepandlungcare.com.au

Epping Level 2, Suite 4A, 230 Cooper Street, Epping 3076
Brunswick 202 Moreland Road, Brunswick 3056
Doncaster East 105 Blackburn Road, Doncaster East 3109
Braybrook Tenancy 2, 330 Ballarat Road, Braybrook 3019
Kilmore 75 Powlett Street, Kilmore 3764

New Patient Registration

Please print clearly
Bring this form with your referral, Medicare card, concession or health-fund card, inhalers and medicines.

Takes about five minutes. You can also complete this online at **sleepandlungcare.com.au/new-patient-registration**. Fields marked * are required. **If you have chest pain, severe breathlessness or another emergency, call 000.**

1 · Your details

TITLE

☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Mx ☐ Dr ☐ Other

FIRST NAME * _____ SURNAME * _____ DATE OF BIRTH * _____

MOBILE * _____ EMAIL * _____

STREET ADDRESS * _____ SUBURB * _____ POSTCODE * _____

PREFERRED CLINIC

☐ Epping ☐ Brunswick ☐ Doncaster East ☐ Braybrook ☐ Kilmore ☐ No preference

DO YOU NEED AN INTERPRETER? IF YES, WHICH LANGUAGE?

_____

2 · Health cover

Please show your Medicare card at reception — we copy it there rather than writing the number on this form. Lung function tests and home sleep studies are bulk billed with a current referral.

CONCESSION CARD

☐ None ☐ Pensioner Concession Card ☐ Health Care Card ☐ Commonwealth Seniors Health Card ☐ DVA Gold Card ☐ DVA White Card

PRIVATE HOSPITAL COVER?

☐ Yes ☐ No

HEALTH FUND (IF YOU HAVE HOSPITAL COVER) _____ MEMBERSHIP NUMBER _____

3 · Your GP

USUAL GP * _____ PRACTICE NAME AND SUBURB * _____

4 · Emergency contact

NAME _____ RELATIONSHIP TO YOU _____ PHONE _____

IF THE PATIENT IS UNDER 18: PARENT OR GUARDIAN NAME AND PHONE

_____

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5 · Your health history (optional — it saves time at your appointment)

WHY HAS YOUR DOCTOR REFERRED YOU?

SMOKING OR VAPING

☐ Never ☐ Ex-smoker ☐ Current smoker ☐ Vape only ☐ Smoke and vape

IF YOU SMOKE OR HAVE SMOKED: HOW MANY PER DAY, AND FOR HOW MANY YEARS?

WORK EXPOSURE TO DUST, SILICA, ASBESTOS, FUMES OR BIRDS?

INHALERS AND OTHER MEDICINES YOU TAKE (NAME AND DOSE)

ALLERGIES TO MEDICINES, FOODS, TAPES OR LATEX

DO YOU USE CPAP OR ANOTHER SLEEP DEVICE?

☐ No ☐ Yes — CPAP ☐ Yes — oral appliance ☐ Yes — other

PREVIOUS SLEEP STUDY OR LUNG FUNCTION TEST (WHERE AND WHEN)

DO YOU DO SHIFT WORK OR DRIVE FOR WORK?

☐ No ☐ Shift work ☐ Drive for work ☐ Both

6 · Consent

☐ **Privacy** * — I have read the Sleep and Lung Care privacy policy (sleepandlungcare.com.au/patients-privacy-policy) and agree to my information being used to arrange my care.

☐ **Cancellations** * — I understand that Sleep and Lung Care asks for at least 48 hours' notice if I cannot attend an appointment, so the time can be offered to another patient.

☐ **SMS** — Send me appointment reminders and information by SMS.

☐ **Email** — Send me appointment information by email.

☐ **AI note-taking** — Some of our physicians use secure AI note-taking software during consultations to prepare notes and letters; no audio recording is kept. I consent to its use in my consultation.

HOW DID YOU HEAR ABOUT US?

☐ My GP ☐ Another specialist ☐ Hospital ☐ Family or friend ☐ Google ☐ Existing patient ☐ Other

SIGNATURE OF PATIENT (OR PARENT / GUARDIAN)

DATE

Office use ☐ Medicare card sighted ☐ Concession / fund card sighted ☐ Referral received Entered by: _____

Date: _____

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