PROFESSOR
Nathan Lawrentschuk
MBBS FRACS FUSANZ PhD
UROLOGIST UROLOGIC ONCOLOGIST ROBOTIC SURGEON

Suite 118, Level 1, 55 Flemington Road
NORTH MELBOURNE VIC 3051
Ph: 03 9329 1197
Fax: 03 9329 2726
Email: info@nathanlawrentschuk.com.au
Healthlink address: nathlawr

TITLE: ..... GIVEN NAME: ..... SURNAME: .....

ADDRESS: ..... SUBURB: .....

STATE: ..... POSTCODE: ..... DATE OF BIRTH: .....MOBILE NUMBER: .....

HOME PHONE NUMBER: ..... EMAIL: .....

MEDICARE NO: ..... REF:..... EXPIRY DATE: .....

DO YOU HAVE PRIVATE HEALTH INSURANCE? YES/NO

HEALTH FUND NAME: ..... MEMBERSHIP NUMBER: .....

PENSION NUMBER (IF APPLICABLE): .....

REFERRING DOCTOR'S NAME: .....

CURRENT GP'S NAME: .....

CLINIC / ADDRESS:.....

OTHER RELEVANT MEDICAL SPECIALISTS / SPECIALTY: .....

CLINIC:.....

NEXT OF KIN / NAME / RELATIONSHIP ..... CONTACT NUMBER:.....

ARE YOU A DIABETIC? YES/NO

DO YOU TAKE ANY FORM OF ANTICOAGULATION? YES/NO

IF YES, NAME OF MEDICATION TAKEN: .....

ANY KNOWN ALLEGIES: .....

PLEASE NOTE THIS IS NOT A BULK BILLING PRACTICE.

PLEASE READ AND SIGN THE FOLLOWING REGARDING INFORMED CONSENT: To comply with Federal and Victorian Privacy Acts, this practice requests you consent to enable us to handle personal information about you.

The information requested is pertinent to your medical condition and will not be disclosed to a third party without your expresses & written consent. Should you feel disinclined to complete any part of this form, it is your right to leave the question unanswered, but it must be acknowledged that in doing so it may compromise or hinder the speedy resolution of your medical/surgical condition.

At any time upon written request, you also have the right to access or correct information held in our records. Please sign your consent to the collection of such information that is requested and that it may be used in conjunction with other medical practitioners in your care and any subsequent surgery.

SIGNATURE:..... DATE:.....