Dr Amir Ashrafi
GASTROINTESTINAL SURGEON

Phone: 02 9145 0300 Fax: 02 9145 5220 Healthlink EDI: aashrafi
Referral: referral@dramirashrafi.com.au Enquiry: info@dramirashrafi.com.au
www.dramirashrafi.com.au

Your Appointment

Using the information you have provided we will assess the level of urgency of your case and then phone you to arrange a suitable time for an appointment. Please be advised we are a private billing practice and fees are payable at the time of consultation.

PLEASE NOTE: If you experience significant changes in the state of your health whilst waiting for your appointment please contact your GP or in the case of an emergency go directly to hospital.

Privacy Statement

Dr Amir Ashrafi supports the importance the community places on the maintenance of confidentiality of individuals' personal and / or sensitive information. This extends to the collection and management of information held in its records regarding individuals. However in order to provide selective services (eg pathology) information is required to be shared between trusted Medical Service Providers. By signing this consent you agree to this practice passing on your personal health information on your behalf:

Patient Signature Date

Do you consent to receiving correspondence from this practice via Email / SMS ☐ YES ☐ NO

Patient Information

Title: First name:

Last Name: Middle name:

Date of birth: Sex: M ☐ F ☐ Gender:

Previous names (eg maiden name):

Occupation:

Address

Suburb: State: Postcode:

Home phone: Business phone:

Mobile phone: Fax:

Email address

Preferred contact method: Home ☐ Business ☐ Mobile ☐ Email ☐

Medicare number: Expiry date: Ref no: (Single digit next to name)

Private health fund name: Member no:

Next of kin full name: Relationship:

Next of kin contact:

Referral Details

GP full name:

Referring doctors name: (if different from GP)

Date of referral: Referring doctor's phone no:

If your referral is not already sent to us by your GP, please attach a copy of it with this form:

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Patient Health Questionnaire

Do you have any allergies? ☐ YES ☐ NO

If yes, what are you allergic to / reaction?

Have you had a faecal occult blood test positive recently? ☐ YES ☐ NO If yes, ☐ POSITIVE ☐ NEGATIVE

Do you take any blood thinning drugs such as *Warfarin, Asasantin, Aspirin, Plavix* or *Iscover*? ☐ YES ☐ NO

Weight kgs Height cms

Have you lost any weight recently? ☐ YES ☐ NO If yes, how much?

Do you take any anti-inflammatory drugs or cortisone? ☐ YES ☐ NO If yes, please list under *Medications* below

Do you take any other medications? If yes, please list under *Medications* below

MEDICATIONS	DOSE	HOW OFTEN?

DO YOU HAVE/EVER HAD ANY OF THE FOLLOWING CONDITIONS:	YES	NO	DETAILS:
High blood pressure	☐	☐	How long?
Chest pain or angina	☐	☐	How often?
Heart attack or coronary stent	☐	☐	When:
Pacemaker, irregular heart beat, palpitations or any other heart condition	☐	☐	What type?
Known peripheral vascular disease? (Occluded vessels in lower limbs)	☐	☐	
Sleep apnoea	☐	☐	
Shortness of breath when climbing stairs or inclines	☐	☐	If yes, how many stairs you can climb without rest?
Shortness of breath when lying flat	☐	☐	
Chronic bronchitis, emphysema	☐	☐	Give details:
Asthma	☐	☐	Requiring hospitalisation?
Diabetes	☐	☐	Do you take insulin / tablets?
Epilepsy or fits	☐	☐	When was the last fit?
Stroke	☐	☐	When?
Blood clots or bleeding disorder	☐	☐	Give details:
Anaemia	☐	☐	What type?
Previous blood transfusion	☐	☐	When?
Stomach ulcers / hiatus hernia / heartburn	☐	☐	Please specify:
Hepatitis or liver disease	☐	☐	What type?
Kidney condition	☐	☐	What type?
Arthritis	☐	☐	What type?
Do or have you ever smoked / vaped?	☐	☐	How many per day? How many years?
Do you drink alcohol?	☐	☐	How many per week?
Is there a condition that runs in the family?	☐	☐	Please specify:

I have read and understood this form and filled it out accurately to the best of my knowledge. Signed:

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