Client registration form

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| **CLIENT DETAILS** | | | | | | | | | | |
| **AC Number:** Enter Text Here. | | | | | | **NDIS Number:** Enter Text Here. | | | | |
| **Salutation:**  Mr/Mrs/Miss | **First name:**  Enter Text Here. | | | | | **Last name:**  Enter Text Here. | | | | |
| **Date of Birth:** DD/MM/YYYY | | | | | | **Gender:**  Female  Male  Other | | | | |
| **Residential Address:** Enter Text Here. | | | | | | | | | | |
| **Suburb:** Enter Text Here. | | | | **State:** Enter Text Here. | | | | | **Postcode:** Enter Text Here. | |
| **Different Postal Address?**  No  Yes - If yes, record below: | | | | | | | | | | |
| **Postal Address:** Enter Text Here. | | | | | | | | | | |
| **Suburb:** Enter Text Here. | | | | **State:** Enter Text Here. | | | | | **Postcode:** Enter Text Here. | |
| **Home/Work Phone:** 04XX XXX XXX | | | | | | **Mobile:** 04XX XXX XXX | | | | |
| **Email Address:** Enter Text Here. | | | | | | | | | | |
| **Prefer method(s) for contact/communication:** | | Home/Work Phone | | | | | Email | | | No Preference |
| Mobile | | | | | Post | | |  |
| **Country of Birth:** Enter Text Here. | | | | | | **Language Spoken at Home:** Enter Text Here. | | | | |
| **Are you of Aboriginal or Torres Islander origin?**  Yes  No  **Do you require an interpreter?**  No  Yes - **Which language/dialect?** Enter Text Here. | | | | | | | | | | |
| **Communication method:** | | Spoken | | | Other Non-Spoken | | | | | No Communication |
| Sign | | |  | | | | |  |
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| **REFERRAL METHOD**  How did you hear about MSWA? | | | | | | | | | | |
| Neuro/GP | | | MSWA Promotional Activity | | | | | Neuro Clinic | | |
| Friend/Family Member | | | Online | | | | | Other: Enter Text Here. | | |

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| **MEDICAL INFORMATION** | | |
| **Neurological Diagnosis:** Enter Text Here. | | |
| **Date of Diagnosis:** Enter Text Here. | | |
| **Have you been diagnosed with any other medical conditions? Please list below:**  Enter Text Here. | | |
| **Do you receive a pension?**  No  Yes | **Have you been ACAT assessed?**  No  Yes | |
| **Do you have health insurance?**  No  Yes – List Health Insurance Provider’s name below. | | |
| **Name of health insurance provider:** Enter Text Here. | | |
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| **DETAILS FOR CLIENT CONTACTS**  (i.e. Next of Kin, Guardian, Carer, Treating Doctor/s) | | |
| **Next of Kin (NOK)/Guardian** | | **Carer (Complete if different to NOK/Guardian)** |
| **First name:** Enter Text Here. | | **First name:** Enter Text Here. |
| **Last name:** Enter Text Here. | | **Last name:** Enter Text Here. |
| **Preferred name:** Enter Text Here. | | **Preferred name:** Enter Text Here. |
| **Relationship to Client:** Enter Text Here. | | **Relationship to Client:** Enter Text Here. |
| **Gender:**  Female  Male  Other | | **Gender:**  Female  Male  Other |
| *Residential address - record below if different to listed for Client on this form* | | |
| **Number/Street:** Enter Text Here. | | **Number/Street:** Enter Text Here. |
| **Suburb:** Enter Text Here. | | **Suburb:** Enter Text Here. |
| **State:** Enter Text Here. | | **State:** Enter Text Here. |
| **Postcode:** Enter Text Here. | | **Postcode:** Enter Text Here. |
| **Preferred Phone:** 04XX XXX XXX | | **Preferred Phone:** 04XX XXX XXX |
| **Email:** Enter Text Here. | | **Email:** Enter Text Here. |
| **Preferred method(s) of communication:** | | **Preferred method(s) of communication:** |
| Phone  Email  Post  No preference | | Phone  Email  Post  No preference |
| **General Practitioner** | | **Neurologist/Specialist** |
| **Do you have a regular GP?**  No  Yes - Record details below. | | **Do you have a Neurologist/Specialist?**  No  Yes - Record details below. |
| **First name:** Enter Text Here. | | **First name:** Enter Text Here. |
| **Last name:** Enter Text Here. | | **Last name:** Enter Text Here. |
| **Gender:**  Female  Male  Unknown | | **Gender:**  Female  Male  Unknown |
| **Practice Address**  **Number/Street:** Enter Text Here. | | **Clinic Address**  **Number/Street:** Enter Text Here. |
| **Suburb:** Enter Text Here. | | **Suburb:** Enter Text Here. |
| **State:** Enter Text Here. | | **State:** Enter Text Here. |
| **Postcode:** Enter Text Here. | | **Postcode:** Enter Text Here. |
| **Preferred Phone:** 04XX XXX XXX | | **Preferred Phone:** 04XX XXX XXX |
| **Email:** Enter Text Here. | | **Email:** Enter Text Here. |

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| **MARKETING SUBSCRIPTION CONSENT**  Would you like to subscribe to marketing communications from MSWA? | |
| This includes our MSWA publications, Client event invitations and other opportunities including research trials. | |
| Yes  No | |
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| **YOUR PRIVACY PROTECTED** | |
| The MSWA Privacy Policy discloses how we collect, protect, use and share information gathered about you.  A copy of MSWA Privacy Policy can be downloaded from our website at [www.mswa.org.au](http://www.mswa.org.au) or you can request a copy by phoning MSWA on (08) 9365 4888. | |
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| **DECLARATION AND SIGNATURES** | |
| * I understand that MSWA requires to collect, hold and use my personal and health information to provide services to me. * I hereby consent to MSWA collecting, storing and using my personal and health information in accordance with the Privacy Act 1988 and its Privacy Policy. * I consent to providing information to MSWA staff to enable them to communicate and liaise appropriately with the other nominated medical, health professionals and services providers involved in my care. | |
| **Client Signature** | |
| **Client Signature:** | **Date:**  DD/MM/YYYY |
| **In the event the Client is unable to sign, nominated representative to sign below** | |
| **Representatives Name:** Representatives Full Name (If required) | |
| **Representatives Signature:** | **Date:**  DD/MM/YYYY |
| **Relationship to Client:** Relationship i.e mum, dad, sister, brother. | |