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.
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| **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. |