THE HUB
Integrated Child Development Solutions

Information Form

Patient Details:			
Surname:		First Name/s:	
Gender:	Date of Birth:	Place of Birth:	
Address:			Post Code:
Phone:		Mobile:	
Home Language:		Year arrived in Australia:	
Cultural background:	Aboriginal: □	Torres Strait Islander: □	Other (Specify):
Accommodation: **Lives with *(please tick appropriate box):***			
Parent(s) □	Other family members □	Hostel □	Group Home □	Other *(please specify):*

Emergency Contact Details:		
Name:	Phone:	Relationship:

Parents Details:		
Mother's Name:	Mother's place of birth:	Mother's DOB:
Address:		Post Code:
Email address:	Mother's Occupation:	
Father's name:	Father's place of birth:	Father's DOB:
Address:		Post Code:
Email address:	Father's Occupation:	
Blended family?	No □ Yes □	
People currently living in household:		

Child in Care of Child Protection & Family Services:		
Child in care of Child Protection & Family Services: Yes □ No □		
Office:	Case Worker:	
Phone:	Mobile:	Email address:
Are any Court Orders in Place? No □ Yes □	***(If Yes please provide a copy)***	
Brothers/Sisters (names and ages):		

Daycare / School Name:	
Daycare or School Name:	Year:
Contact name:	Phone:
Address:	Post Code:

Past Medical History:
Allergies:
Current Medications:
Immunisations up to date? Yes □ No □
Other relevant information:
Previous Services Attended? Yes □ No □
Summary of Services:

Medicare and Referral information:			
Medicare No:	Child Ref No:	Parent Ref No:	Parent DOB:
Private Health Fund:			Member No:
Referring Doctor:		Provider No:	
Practice:		Referral Date:	

Client/Parent consent to collect and disclose information

The Privacy Amendment (Enhancing Privacy Protection) Act 2012 which amends the Privacy Act 1988 continues to require medical and allied health practitioners to obtain consent from individuals (and/or guardians) to collect, use and disclose the client's personal information. Both practice staff and the practitioners may participate in the collection of this information.

I provide consent for The Hub: Integrated Child Development Solutions/Youth Mental Health Service to collect, use and disclose mine or my child's personal information to other medical practitioners, health care providers and hospitals.

I acknowledge that all debts owed in relation to the provision of services for myself or my child (including charges for appointments not kept) are my responsibility and that all expenses incurred in recovering any debt owed for the provision of services is my responsibility.

Signature of Parent/Guardian/Self: Date: