Client Intake Form

IMPORTANT NOTICE: The information contained in this document is confidential. If you receive this message in error, please notify us immediately and return the original message to Diabetes WA.

MY HEALTH RECORD: The Diabetes WA Clinic accesses My Health Record prior to and during appointments. If you do not want us to access your My Health Record, please contact us at least 1 business day before your appointment.

Client Details (please complete ALL sections)			
Title:	Surname:	Given names:	
Address:			Postcode:
DOB:	Gender:	Aboriginal Torres Strait Islander Both	
Telephone:	Mob:	Email:	
Medicare Number:		Reference No:	Expiry Date:
Health Care Card Number:		Language: Interpreter Required: Yes No	
Next of Kin Details			
Name		Relationship	
Telephone		Email	
Do you have a doctor's referral? Yes No. If yes, please send to us or bring to your appointment			
Usual General Practitioner:			
Title: Dr	Surname:	Given Names:	
Practice Name:	Address:		Postcode:
Telephone:	Email:		Facsimile:
Diabetes Type (please check)			
Type 1 Type 2 Type 2 insulin Other:			Date of Diagnosis:
Pre-diabetes Includes insulin resistance, at risk of diabetes		NDSS Registration: Yes No	NDSS No:
Blood Glucose Monitoring: Yes No (check)		**Insulin Pump:** Yes No (list below)	
Finger Prick Dexcom G6 Freestyle Libre Guardian Connect/Link 3			
Medications: Yes No (List dosage & frequency)		**Insulin:** Yes No (List dose & frequency)	
Other Medical Conditions: Yes No (Please list below)			
Allergies: Yes No (Please list below)			
What is your goal for the appointment:			

Diabetes Education Declaration and Consent Form

In signing below, I acknowledge I have read, understand, and accept the following:

- I declare that the information entered above is truthful and correct to the best of my knowledge.
- I declare that I have read and accept the Terms and Conditions listed below.
- If I require insulin adjustment advice, I confirm that I will ensure my GP or endocrinologist has completed and signed the Insulin Authority Form before my scheduled appointment.
- I understand that my personal and health information will be treated in accordance with the Diabetes WA Privacy Policy covered by the Privacy Act 1988. Details of this policy are available on request.
- I consent to my Diabetes WA Clinic diabetes educator to discuss relevant parts of my treatment with my treating doctor and other healthcare team.
- Private Health Insurance and Medicare claims will be processed after full payment for services for your convenience. If the claim is declined, I accept responsibility for payment of all outstanding accounts. I authorise Diabetes WA to debt my nominated card for payment for services rendered as part of treatment.
- I understand that informed consent is required prior to receiving any service offered by the Diabetes WA Clinic, and that I may withdraw my consent at any time by informing the Diabetes WA Clinic in writing.
- I understand that there is the potential for serious risks involved with adjusting insulin and with some diabetes treatment options.
- In signing below, I consent to receiving treatment and clinical services provided by the Diabetes WA Clinic until such time that I withdraw my consent.

Please see appointment Terms and Conditions https://www.diabeteswa.com.au/terms-and-conditions/

Signature:

Date:

Name: