A/PROF MEHRDAD NIKFARJAM MD, PhD, FRACS
Liver, Pancreas and Biliary Surgeon
Laparoscopic Surgeon

Correspondence and appointments
Phone: (03) 94585100
E info@lpbsurgery.com

Patient Registration Form

MR/MRS/MISS/MS_____ _____
(Given Names) (Surname)

Date of Birth _____ Address _____
_____ Postcode _____

Email: _____

Phone:
(H) _____ (B) _____ (M) _____

_____

Medicare NO _____ Ref No (e.g. 1, 2) ___ Valid to _____

Veterans' Affairs NO _____ Gold card or White card (please circle)

_____

Private Health Fund- Private Hospital Cover- YES or NO (please circle)

Fund name _____ Number _____

Level of Cover _____ Membership over 12 months YES or NO (Please circle)

_____

Next of Kin
Name _____ Relationship _____

Address _____

Phone
(H) _____ (B) _____ (M) _____

_____

Doctors'

Referring Doctor _____ (Ph) _____

Address _____

_____

GP/Family Doctor _____ (PH) _____

Address _____

_____

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PRIVACY AND PERSONAL INFORMATION: (Please read carefully)

In the course of managing your health/medical issues/personal information Mr Mehrdad Nikfarjam or his representatives in this practice may need to collect personal information about you for the purpose of providing the best possible care.

In the course of managing your health/medical issues/personal information they also may need to disclose your personal information to: other health professionals, rehabilitation services, employers, and government entities where there are obligations under law to do so.

SIGNED CONSENT

I ……..

(Write full name)

of ……

(Full private address)

Date of birth ……../……/……..

hereby authorise and consent to any doctor, health professional, hospital or other health institution or rehabilitation provider which has examined me to discuss with and provide Mr Mehrdad Nikfarjam or any of his representatives in this practice any reports, clinical notes or relevant information relation to my health.

I understand that the medical information is required for the purpose of assisting with my medical treatment.

I authorise and consent to a photocopy of this Authority being sufficient evidence of my authority and consent to discuss or provide medical information requested.

Signature …….. Date ……/……./……

(Patient)

☐ Please tick if you would like to be include in the contact list for PANCARE Foundation, a not-for-profit organisation dedicated at pancreatic, liver, biliary and foregut cancer awareness, research and education. You can always choose to be removed from this list in the future.