



## Welcome to Garden City Eye Clinic.

Please find below some information about your first visit as well as a short **Confidential New Patient Questionnaire**.

A valid referral is required to receive a Medicare benefit for the service. Referrals from General Practitioners and Optometrists are valid for 12 months and referrals from other Specialists are valid for 3 months.

We are a private billing practice and there will be a gap to pay for consultations and procedures. For consultations we ask that you please settle your account on the day. Credit card and EFTPOS facilities are available. We are happy to provide an estimate of your out-of-pocket expenses – please just ask.

You may receive drops at your appointment to dilate your pupils to examine your eyes. This may make your vision glary for up to 6 hours after your appointment. It is not recommended that you drive while your vision is affected.

Please complete the enclosed **Confidential New Patient Questionnaire** and bring this to your appointment. Alternatively, please bring a list of your medications and arrive 15 minutes early to complete the form in the rooms. You may also bring a Health Summary from your GP.

### **Please also bring your:**

- » Current glasses
- » Medicare Card or Department of Veterans Affairs (DVA) Card
- » Private Health Insurance details

Garden City Eye Clinic is located at Suite 18, Ground Floor, Building 3, St Andrew's Hospital, 280 North Street, Toowoomba. The St Andrew's Hospital map can be found at <http://www.sath.org.au/about-us/where-to-find-us>. Please drive in via Entrance 2 off North St and head to the circular patient drop-off zone beside Building 3. Our clinic is on this level and only a short distance away. Please note that this entrance is not the Main Hospital Entrance. Free parking is available in the hospital car park. There is full wheel chair access to the hospital and our clinic.



**GARDEN CITY**  
EYE CLINIC

**DR MICHAEL STATHAM**  
MBBS (Hons 1) BAppSc (Optom) (Hons 1) FRANZCO  
Monash Fellowship (Cataract Surgery & Medical Retina)  
OPHTHALMOLOGIST

## CONFIDENTIAL NEW PATIENT QUESTIONNAIRE

Date of completion of this form \_\_\_\_\_

Name of patient (include preferred title please) \_\_\_\_\_

D.O.B. \_\_\_\_\_

Postal Address \_\_\_\_\_  
\_\_\_\_\_

Home phone \_\_\_\_\_

Mobile phone \_\_\_\_\_

Contact email address \_\_\_\_\_

Name of person completing this form (if different from patient) \_\_\_\_\_

Next of Kin details for emergency contact

Name \_\_\_\_\_ Phone \_\_\_\_\_

Your General Practitioner \_\_\_\_\_

Your Optometrist \_\_\_\_\_

Medicare number \_\_\_\_\_

Card reference number \_\_\_\_\_ Expiry date \_\_\_\_\_

Private Health Insurance provider \_\_\_\_\_

Member number \_\_\_\_\_ Card reference number \_\_\_\_\_

Is eye surgery covered on your policy  Yes  No

Department of Veterans Affairs (DVA) member number \_\_\_\_\_

Card type  Gold  White  Orange



Would you like us to discuss matters related to your health care with your relatives and friends if the need arises (privacy disclosure)?  Yes  No

Is there a legal arrangement in place in case you are unable to make your own decisions about medical treatment (e.g. Enduring Power of Attorney)?  Yes  No Please list names and contact numbers

Name \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_

Please list any significant medical conditions (including eye conditions) or attach list. Please include any eye diseases that run in the family \_\_\_\_\_  
\_\_\_\_\_

Please list your current medications or attach list. Include eye drops, anticoagulants or blood thinners, any prostate related medicines ever taken (e.g. Flomax or Minipress), puffers and natural health supplements  
\_\_\_\_\_  
\_\_\_\_\_

Please list any allergies and the nature of the reaction (include medicines, natural substances and latex)  
\_\_\_\_\_

Females only: Are you or could you be pregnant? \_\_\_\_\_ Are you breastfeeding? \_\_\_\_\_

Do you smoke (how much per day and for how long)? \_\_\_\_\_

Have you or any relative ever had a complication related to an anaesthetic (please give details)?  
\_\_\_\_\_

What is your occupation? \_\_\_\_\_

Do you drive a car or other vehicle? \_\_\_\_\_

Do you suffer from claustrophobia? \_\_\_\_\_

Can you lie flat on one pillow without becoming too short of breath? \_\_\_\_\_