

# Gold Coast Hand & Upper Limb Clinic

Dr Angelo Rando

SALUTATION	MR / MRS / MS / MISS / MASTER		
SURNAME			
GIVEN NAMES			
ADDRESS			
			Postcode
DATE OF BIRTH		MALE	FEMALE
HOME Phone			
WORK Phone			
MOBILE No			
EMAIL ADDRESS			
MEDICARE NO.			Exp. Date:
Medicare Card Reference. #	ie: the number on <b>the left beside</b> your name:		
HEALTH FUND			
MEMBER/POLICY NO.			
Pension Card No:			Exp. Date:
DVA Card No:			
FAMILY DR If different from referring Dr			
Clinic & Address (If known)			
Are you taking:- Please tick if YES	Warfarin <input type="checkbox"/>	Plavix <input type="checkbox"/>	Cartia <input type="checkbox"/> Aspirin <input type="checkbox"/>
Do you have any allergies?	Please give details:	Are you Diabetic? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Have you seen a Physiotherapist ? Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, who?	Have you seen a Hand Therapist? Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, who?		
OCCUPATION			
Emergency Contact Name:		Relationship eg: Wife/Husband, Mother, friend	
Ph Number:			
<b>WORKCOVER PATIENTS – THESE FIELDS MUST BE COMPLETED</b>			
WORKCOVER (or Insurance) CLAIM NO:			Location where injury occurred
INJURY DATE			
WHAT IS THE INJURY?	How did injury occur?		