|  |  |
| --- | --- |
| **FULL NAME** |  |
| **DATE OF BIRTH** |  |
| **CURRENT ADDRESS** |  |
|  |  |
| **ALLERGIES:** |  |
|  |  |
| **URGENT MED INFO** | E.g.- On blood thinners |
| **MEDICAL CONDITIONS** | E.g.- Heart disease/Lupus/RA/Asthma |

**PATIENT DETAILS AND ALLERGIES**

**DETAILS OF HEALTH-RELATED CARDS**

|  |  |
| --- | --- |
| **MEDICARE NUMBER** | **EXP:** |
| **HEALTHCARE**  **CARD NUMBER** | **EXP:** |
| **OTHER CARD NUMBER (Healthcare related)** | **EXP:** |

**EMERGENCY CONTACTS AND DOCTORS DETAILS**

|  |  |
| --- | --- |
| **NEXT OF KIN** | **Name- Phone no- Relationship** |
| **OTHER EMERG CONTACT** | **Name- Phone no- Relationship** |
|  |  |
| **General Practitioner (GP)** | **Name- Phone No- Medical centre address** |
| **SPECIALIST** | **Name- Phone No- Medical clinic address** |
| **SPECIALIST** | **Name- Phone No- Medical clinic address** |
| **SPECIALIST** | **Name- Phone No- Medical clinic address** |
| **SPECIALIST** | **Name- Phone No- Medical clinic address** |
| **SPECIALIST** | **Name- Phone No- Medical clinic address** |
| **OTHER MEDICAL CONTACT** | **Name- Phone No- Medical clinic address** |

**CURRENT MEDICATIONS**

*(Example included in chart below/delete before using form)*

*Press enter to add spaces (or) copy and paste a line from below.*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **MEDICATION NAME** | **ALSO KNOWN AS** | **DOSE** | **FREQUENCY** | **TO TREAT** |
| Ventolin  **Example (delete before use)** | Asmol | 2 puffs | As required | Asthma |
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**DIET / FOOD**

|  |  |
| --- | --- |
| **FOOD ALLERGIES** |  |
| **SPECIAL FOOD REQUIREMENTS** |  |

**OTHER / NOTES**

|  |  |
| --- | --- |
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|  |  |