Lift Cancer Care Services

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PERSONAL DETAILS

Gender: ☐ Male ☐ Female ☐ Non Binary ☐ Transgender	
Title: ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Other	Date of Birth:
Given names:	Surname:
Preferred name:	Marital Status:
Preferred pronouns: ☐ He/Him ☐ She/Her ☐ They/Them ☐ Other	Sexuality: ☐ Heterosexual ☐ Homosexual ☐ Bisexual ☐ Prefer not to say ☐ Other
Nationality:	Country of birth:
Preferred language:	Do you identify as ☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Neither
Employment status:	Occupation:
Street Address:	
Suburb:	Post Code:
Postal address (if different to above):	

Phone:	Home:	Mobile:	Work:
Email:	Are you willing to receive communication via email and SMS?		

EMERGENCY CONTACTS

Next of kin (first contact in an emergency)	
Given names:	Surname:
Address:	
Phone:	Relationship to patient:
Emergency contact (must be different from next of kin; will be second point of contact in an emergency)	
Given names:	Surname:
Address:	
Phone:	Relationship to patient:

CONCESSION AND HEALTH COVER

Medicare		
Medicare number:	Ref:	Expiry:
Department of Veterans Affairs		
☐ Gold ☐ White		
Card number:		Expiry:
Private health		
Name of fund:		
Membership number:	Position on card:	

MEDICAL HISTORY

Do you have an Advanced Care Directive? ☐ Yes ☐ No

Tobacco

Do you, or have you ever smoked?

☐ Never ☐ Ceased smoking (year ceased .....) ☐ Smoker (..... cigarettes per day / week

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ALLERGIES

Do you have any allergies to any of the following?		
Drug /natural remedy	☐ Y	Details:
Latex / Rubber	☐ Y	Details:
Adhesive tape	☐ Y	Details:
Food	☐ Y	Details:
Lotions	☐ Y	Details:
Other	☐ Y	Details:

MEDICATIONS

Please list your current medications: (please attach extra sheet if required)

CANCER HISTORY AND TREATMENT

Cancer type	Date of diagnosis	Date you finished treatment
Oncology surgery		
What surgery did you have?	Date of surgery	Surgeon
Chemotherapy		
How many cycles of chemotherapy did you complete?	Oncologist:	
Radiotherapy		
How many sessions of radiotherapy did you have?	Radiation Oncologist:	
Hormone treatment		
Name of treatment? When did this start and finish?		

INFECTION CONTROL ASSESSMENT

Have you had any of the following recently? *(circle)* Cough / Cold / Chest infection	☐ Y	☐ N
Are you currently taking antibiotics?	☐ Y	☐ N
Have you had any illnesses such as gastroenteritis within the last 14 days?	☐ Y	☐ N
Have you been in contact with someone who has had chicken pox within the last 14 days?	☐ Y	☐ N
Have you recently been in contact with a known case of COVID-19	☐ Y	☐ N

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INFORMATION SHARING CONSENT

It is important that we can communicate with your treating doctors to ensure safe and effective care.
Lift Cancer Care Services requires your consent to collect personal information. Please read this consent form carefully, tick the applicable boxes and sign below. I have been informed and understand how this information will be used, and that this information will not be passed on to other third parties except to those detailed on this consent information form.

I give permission for my personal health information to be used for admin purposes to assist the running of Lift Cancer Care Services and for providing quality health care, including disclosure to others involved in my healthcare, such as treating doctors and specialists. *My treating Doctors who I give information sharing consent to are:* **General Practitioner** (GP): _____ **Name of Practice:**_____ **Medical Oncologist:** **Radiation Oncologist:** **Surgeon:**	☐
I give consent for disclosure of my clinical information (x-rays, biopsy results and clinical data) to be used for discussion with the clinicians I have provided on this sheet below:	☐
I understand that by ticking the relevant boxes above that Lift Cancer Care Services is authorised on my behalf to use my relevant personal health information and I am free to withdraw my consent at any time by verbal or written notification	☐
I give consent for my de-identified information to be used in research and commercial development. All information will be handled in accordance with relevant privacy legislation.	☐
OR	
I am unsure and would like to discuss this further with someone from the LIFT team before I sign	☐

Patient's signature:	**Patient Name:**	**Date:**

BASIC LIFE SUPPORT AND RESUCITATION CONSENT

In the event that you experience an episode of medical deterioration while at LIFT, it is our
Policy to begin Basic Life Support. This includes calling an ambulance, cardio-pulmonary resuscitation, supplementary oxygen, suction and use of a defibrillator as clinically indicated.
If you do not consent to this, we will not be able to accept you for exercise medicine.

I give consent for Basic Life Support as detailed above		☐
I DO NOT give consent for Basic Life Support as detailed above	*ADMIN – If this box is ticked patient CAN NOT attend for exercise medicine*	☐
OR		
I am unsure and would like to discuss this further with someone from the LIFT team before I sign		☐

Patient's signature:	**Patient Name:**	**Date:**

FINANCIAL CONSENT

At LIFT we understand that at times you may need to reschedule your appointment due to illness or unforeseen circumstance, however we would appreciate as much notice as possible.

I understand that I am required to give at least 24 hours' notice if I am unable to attend an appointment. Failure to do so will result in a non-attendance fee	☐

Patient's signature:	**Patient Name:**	**Date:**

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PRE-EXERCISE SCREENING TOOL

***PLEASE COMPLETE IF YOU HAVE NOT BEEN REFERRED TO LIFT BY YOUR DOCTOR OR SPECIALIST**

		If YES, please provide details including current management	
Has your Medical Practitioner ever told you that you have a heart condition, or have you ever suffered a stroke?	☐ Y		☐ N
Do you ever experience unexplained pains of discomfort in your chest at rest or during physical activity/exercise?	☐ Y		☐ N
Do you ever feel faint, dizzy or lose balance during physical activity/exercise?	☐ Y		☐ N
Have you had an asthma attack requiring immediate medical attention at any time over the last 12 months?	☐ Y		☐ N
If you have diabetes (type 1 or 2) have you had trouble controlling your blood sugar (glucose) in the past 3 months?	☐ Y		☐ N
Do you have any other condition that may require special consideration for you to exercise?	☐ Y		☐ N

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Below is a list of statements that other people with your illness have said are important**.**
Please circle to indicate your response as it applies to the <u>past 7 days</u>.

	PHYSICAL WELL-BEING	**Not at all**	**A little bit**	**Some-what**	**Quite a bit**	**Very much**
GP 1	I have a lack of energy	0	1	2	3	4
GP 2	I have nausea	0	1	2	3	4
GP 3	Because of my physical condition, I have trouble meeting the needs of my family	0	1	2	3	4
GP 4	I have pain	0	1	2	3	4
GP 5	I am bothered by side effects of treatment	0	1	2	3	4
GP 6	I feel ill	0	1	2	3	4
GP 7	I am forced to spend time in bed	0	1	2	3	4

	SOCIAL/FAMILY WELL-BEING	**Not at all**	**A little bit**	**Some-what**	**Quite a bit**	**Very much**
GS 1	I feel close to my friends	0	1	2	3	4
GS 2	I get emotional support from my family	0	1	2	3	4
GS 3	I get support from my friends	0	1	2	3	4
GS 4	My family has accepted my illness	0	1	2	3	4
GS 5	I am satisfied with family communication about my illness	0	1	2	3	4
GS 6	I feel close to my partner (or the person who is my main support)	0	1	2	3	4
Q1	*Regardless of your current level of sexual activity, please answer the following question. If you prefer not to answer it, please mark this box and go to the next section.* ☐					
GS 7	I am satisfied with my sex life	0	1	2	3	4

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	EMOTIONAL WELL-BEING	Not at all	A little bit	Some-what	Quite a bit	Very much
G E1	I feel sad	0	1	2	3	4
G E2	I am satisfied with how I am coping with my illness	0	1	2	3	4
G E3	I am losing hope in the fight against my illness	0	1	2	3	4
G E4	I feel nervous	0	1	2	3	4
G E5	I worry about dying	0	1	2	3	4
G E6	I worry that my condition will get worse	0	1	2	3	4

	FUNCTIONAL WELL-BEING	Not at all	A little bit	Some-what	Quite a bit	Very much
G F1	I am able to work (include work at home)	0	1	2	3	4
G F2	My work (include work at home) is fulfilling	0	1	2	3	4
G F3	I am able to enjoy life	0	1	2	3	4
G F4	I have accepted my illness	0	1	2	3	4
G F5	I am sleeping well	0	1	2	3	4
G F6	I am enjoying the things I usually do for fun	0	1	2	3	4
G F7	I am content with the quality of my life right now	0	1	2	3	4

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PARTNERING WITH CONSUMERS

Date of Issue: Nov 2017 **Next Revision Date: Dec 2020**	**Ref No: PC020** **Name: Privacy Acknowledgement Form**	**Authorised by:** **Lauren Whiting**

YOUR PRIVACY

We require your consent to collect personal information about you. Please read this information carefully and sign where indicated.

This medical practice collects information from you for the primary purpose of providing quality health care. We require you to provide us with your personal details and a full medical history so that we may properly assess, diagnose, treat and be proactive in your health care needs. This means we will use the information you provide in the following ways:

- Administrative purposes in running our facility
- Billing purposes, including compliance with Medicare and Health Fund requirements
- Disclosure to others involved in your health care, including treating doctors and specialists that may be outside this practice. This may occur through referral to other doctors or for medical tests, and in the report/s or result/s returned to us following any referrals
- Disclosure to our multi-disciplinary team in the practice for the purpose of discussing your health care to ensure your safety, appropriate treatment planning for the best possible outcomes during your treatment
- Disclosure to professional medical bodies if applicable
- Disclosure for evaluation and quality assurance activities to improve individual and community health care and practice management according to our Privacy Policy

Please let us know if you do not want your records assessed for these purposes, and we will note your request accordingly.

I have read the information above and understand the reason why my information must be collected. I am also aware that this practice has a Privacy Policy on handling patient information.

I understand that I am not obliged to provide all information requested of me, but that my failure to do so may compromise the quality of the health care and treatment given to me.

I am aware of the right to access the information collected about me, except in some circumstances where access might legitimately be withheld. I understand I will be given an explanation in these circumstances.

I understand that if my information is to be used for any other purpose other than set out above, my further consent will be obtained.

I consent to the handling of my information by this practice as outlined above subject to any limitations on access or disclosure that I notify this practice of.

NAME:_____DOB_____/_____/_____

ADDRESS:_____

SIGNATURE:_____DATE:_____