Lift Cancer Care Services

Affix Patient Sticker

PERSONAL DETAILS

Gender: ☐ Male ☐ Female ☐ Non Binary ☐ Transgender ☐ Other	
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?	☐ Y	☐ N

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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Do you have any of the following:					
Heart issues? *(circle)* Heart attack / Angina / Palpitations / Heart murmur / Irregular heart beat	☐ Y	☐ N	Elimination issues? *(circle)* Bowel problems / Bladder problems / Incontinence	☐ Y	☐ N
High blood pressure issues (circle) High / Low Blood Pressure	☐ Y	☐ N	*(circle)* Strokes / Mini Strokes / MS / Motor Neurone Disease / Brain surgery?	☐ Y	☐ N
Peripheral Vascular Disease?	☐ Y	☐ N	Parkinson's Disease?	☐ Y	☐ N
Implant devices or prosthesis? *(circle)* Joint / heart valve / lap band / stents / stimulators / shunts / eye lens / other	☐ Y	☐ N	*(circle)* Short term memory loss / Confusion / Dementia?	☐ Y	☐ N
(circle) Asthma / Bronchitis / Emphysema / Shortness of breath / Pneumonia / TB?	☐ Y	☐ N	*(circle)* Mental illness / Anxiety / Depression?	☐ Y	☐ N
Diabetes? *(circle)* Type 1 / Type 2	☐ Y	☐ N	Have you been diagnosed with chronic pain?	☐ Y	☐ N
(circle) Blood disorders / Bleeding problems / Bruise easily / Anaemia?	☐ Y	☐ N	Skin conditions? *(circle)* Existing wounds / Pressure areas / Ulcers	☐ Y	☐ N
(circle) Blood clots in legs / lungs?	☐ Y	☐ N	*(circle)* Faints / Black outs / Dizzy spells	☐ Y	☐ N
Blood transfusion?	☐ Y	☐ N	Falls in the last 12 months?	☐ Y	☐ N
Arthritis?	☐ Y	☐ N	Hearing impairment?	☐ Y	☐ N
Epilepsy or seizures?	☐ Y	☐ N	Vision impairment?	☐ Y	☐ N

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)

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CANCER HISTORY AND TREATMENT

Cancer diagnosis and history

Oncology surgery

What surgery did you /will you have? What date was /is surgery?

Chemotherapy

How often did you/will you have chemo? How many cycles completed/planned?

Radiotherapy

Is this part of your treatment? ☐ Y ☐ N	**If YES:** Start Date: Finish Date:	**Genesis** ☐ Y ☐ N **ICON** ☐ Y ☐ N **RAH** ☐ Y ☐ N

Hormone treatment

Name of treatment? When did you start? **OR** When is it planned to start?

SIDE EFFECTS OF TREATMENT

Have you experience any of these symptoms?					
Fatigue	☐ Y	☐ N	Weight gain or loss	☐ Y	☐ N
Depression	☐ Y	☐ N	Change in appetite	☐ Y	☐ N
Anxiety	☐ Y	☐ N	Pain	☐ Y	☐ N
Difficulty sleeping	☐ Y	☐ N	Shortness of breath	☐ Y	☐ N
Nausea	☐ Y	☐ N	Muscle pain	☐ Y	☐ N
Joint stiffness	☐ Y	☐ N	Lymphoedema	☐ Y	☐ N
Fractures	☐ Y	☐ N	Peripheral Neuropathy	☐ Y	☐ N

FALLS RISK SCREENING

Aged >65	☐ Y	☐ N	Difficulty sleeping	☐ Y	☐ N
Has a condition associated with increased risk of falls?	☐ Y	☐ N	Has had one or more falls in the past 6 months	☐ Y	☐ N
Younger and unsteady	☐ Y	☐ N	Aboriginal or Torres Strait Islander and aged >50	☐ Y	☐ N
Staff use: If answered YES to any complete FRAT	FRAT completed ☐ Y		Date:	Initial:	

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
Are you vaccinated for Covid-19? ☐ **1 Dose** ☐ **2 Doses** ☐ **3 Doses** ☐ **4 or more Doses**		☐ **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. By agreeing to give my consent, I 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 form unless otherwise agreed to.

My treating Doctors who I give information sharing consent to are:

	Doctor's name	Practice name	Suburb	Please tick:
General Practitioner				☐
Medical Oncologist				☐
Radiation Oncologist				☐
Surgeon				☐
Cardiologist **Last Seen:**				☐
Other				☐

- I understand that by ticking the relevant boxes above, that Lift Cancer Care Services is authorised on my behalf to collect and receive relevant personal information and health information.
- I understand I am free to withdraw my consent at any time by verbal or written notification.
- I give permission for my personal information and health information to be used for providing quality health care and treatment, including disclosure of such information to others involved in my healthcare (e.g. treating doctors, clinicians and specialists), and for administrative purposes.
- I give consent for disclosure of my clinical information (such as x-rays and scans, biopsy results, blood test reults, and other clinical data) to be used for discussion and treatment with the clinicians I engage with at Lift Cancer Care.
- I give consent for my de-identified information to be used in research and 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

I understand that the payment for any treatment is my responsibility. In some instances there might be a rebate applicable from Medicare, a Private Health Fund or DVA, which will be applied **after full** payment of my account, however if no rebate is applicable by signing below I agree to pay my account in full.

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

FACT-G (Version 4)

NAME: Date of Birth:
DATE:

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	Somewhat	Quite a bit	Very much
GP1	I have a lack of energy	0	1	2	3	4
GP2	I have nausea	0	1	2	3	4
GP3	Because of my physical condition, I have trouble meeting the needs of my family	0	1	2	3	4
GP4	I have pain	0	1	2	3	
GP5						
	4					
GP6						
GP7	I am bothered by side effects of treatment	0	1	2	3	4
	I feel ill	0	1	2	3	4
	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
GS1	I feel close to my friends	0	1	2	3	4
GS2	I get emotional support from my family	0	1	2	3	4
GS3	I get support from my friends	0	1	2	3	4
GS4	My family has accepted my illness	0	1	2	3	4
GS5	I am satisfied with family communication about my illness	0	1	2	3	4
GS6	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.*					
GS7	I am satisfied with my sex life	0	1	2	3	4

FACT-G (Version 4)

NAME: Date of Birth:

DATE:

Please circle to indicate your response as it applies to the past 7 days.

	EMOTIONAL WELL-BEING	Not at all	A little bit	Some-what	Quite a bit	Very much
GE1	I feel sad	0	1	2	3	4
GE2	I am satisfied with how I am coping with my illness	0	1	2	3	4
GE3	I am losing hope in the fight against my illness	0	1	2	3	4
GE4	I feel nervous	0	1	2	3	4
GE5	I worry about dying	0	1	2	3	4
GE6	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
GF1	I am able to work (include work at home)	0	1	2	3	4
GF2	My work (include work at home) is fulfilling	0	1	2	3	4
GF3	I am able to enjoy life	0	1	2	3	4
GF4	I have accepted my illness	0	1	2	3	4
GF5	I am sleeping well	0	1	2	3	4
GF6	I am enjoying the things I usually do for fun	0	1	2	3	4
GF7	I am content with the quality of my life right now	0	1	2	3	4

PARTNERING WITH CONSUMERS

Date of Issue: Nov 2017 **Next Revision Date: Nov 2024**	**Ref No: PC020** **Name: Privacy Acknowledgement Form**	**Authorised by:** **Lauren Whiting**

YOUR PRIVACY

Lift Cancer Care operates under The Australian Privacy Principles which are the cornerstone of the privacy protection framework in the Privacy Act 1988. 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:

- To provide appropriate services and treatment
- Make decisions based on the information you have provided
- Liaison with others involved in your health care, including treating doctors and specialists that may be outside this practice
- Liaison with various multi-disciplinary teams for the purpose of discussing your health care in planning for the best possible outcomes
- administrative purposes
- billing purposes

Lift Cancer Care can't use or disclose your personal information for another reason (a secondary purpose) unless an exception applies. Exceptions include:

- Lessening or preventing a serious threat to life, health or safety where it is unreasonable or impracticable to obtain the individual's consent
- Necessary to prevent a serious threat to the life, health or safety of a genetic relative
- Disclosure to a responsible person for an individual
- Taking appropriate action in relation to suspected unlawful activity or serious misconduct
- Reasonably necessary for establishing, exercising or defending a legal or equitable claim
- Reasonably necessary for a confidential alternative dispute resolution process
- Conducting research; compiling or analysing statistics; management, funding, quality assurance or monitoring of a health service (extra other conditions apply)
- Using or disclosing personal information as required or authorised by law

PRIVACY ACKNOWLEDGEMENT

- 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 that I notify this practice of:

NAME:_____DATE OF BIRTH_____/_____/_____

ADDRESS:_____

SIGNATURE:_____DATE:_____

Lift Cancer Care Services

The Tennyson Centre
520 South Road
KURRALTA PARK SA 5037
Hospital Provider Number: 0067230J
Phone: 08 7231 8000 Fax 08 7200 3108

_____
_____
_____

REQUEST FOR PATIENT HEALTH SUMMARY

The patient below has been referred to us by their treating Oncology Practitioner to present for an Initial Assessment in order for them to access our range of support services.

To accurately assess the patient prior to treatment, our Medical Practitioner requests their Health Summary, including active and inactive past medical history, medications, and allergies. We encourage all of our patients to have continuity of care with their regular GP, and the role of our Medical Practitioners at Lift is not to take over this long-term care.

The patient has provided their consent to share this information below.

Can you please arrange to have this faxed through ASAP to our Day Hospital on (**08)** 7200 3108 **(must use area code as is a virtual fax).**

Thank you for your prompt attention to this matter. If you have any queries please contact us on 08 7231 8000

Patient Name: _____

(First) *(Last)*

Date of Birth: _____

Address: _____

I, _____ hereby give permission for my Health Summary to be faxed through to Lift Cancer Care Services

Patient Signature: _____ Date: _____

Lift Cancer Care is an Accredited Licensed Day Hospital offering a range of support services for Oncology patients from diagnosis, through their treatment and post-treatment.

Our services include Prescribed Exercise Medicine, Dietetics, Clinical Psychology, Physiotherapy, Lymphoedema Screening, Lymphoedema Massage, and Speech Pathology