Dietetic Client Registration Form

Personal Details:		
Title:	First Name:	Surname:
D.O.B: / /	Address:	
Suburb:		Post Code:
Contact No Home:	Work:	Mobile:
Occupation:	Email:	
Next of Kin / Name:	Relationship:	Contact No:

Referral Details (please tick & complete):				
Source:	☐ General Practitioner:		☐ Social Media:	
			☐ Sporting Club:	
	☐ Friend / Relative:		☐ Advertisement / Signage:	
	☐ Google:		☐ Other:	

Payment Method (please tick):		
☐ Private / Self	☐ Medicare / Chronic Disease Management Plan	☐ Department of Veterans Affairs
☐ Other	☐ Office Use Only	

Dietary Assessment Form:
Reason for referral (describe your condition):
Have you seen another Dietitian previously? ☐ Yes ☐ No
Current medications / supplements (if any): Current insulin regime (if any):
Clinical issues affecting diet (i.e. vomiting / nausea / diarrhea / constipation):

Suite 7, 2 Queensgate Drive Canning Vale WA 6155
Phone (08) 6162 2616
www.wahealthgroup.com.au
Physiotherapy | Exercise Physiology | Dietitian | Podiatry | Remedial Massage

Recent pathology results e.g. high total and LDL cholesterol levels:
Social history e.g. who does the cooking / grocery shopping:

ALL PATIENTS: Please read the following and indicate your understanding by signing and dating below

ACCOUNT RESPONSIBILITY & SETTLEMENT:

I acknowledge that I am responsible for the payment of any accounts incurred to myself through WA Health Group. I undertake to pay all accounts in a timely manner. I understand that any expense, cost or disbursements incurred by this practice in recovering any outstanding monies will be repaid by myself.

PRIVACY

I authorize WA Health Group to discuss my treatment and medical condition with my other treating professionals, and or insurer or employer that is responsible for my payment of my account. Our privacy statement is available on request should you wish to view this in its entirety.

CANCELLATION OF APPOINTMENT:

If you are unable to attend an appointment, please provide us with a minimum of 8 hours' notice by phone. Missed appointments may incur a non-attendance fee (full consultation fee).

CONSENT:

- I authorize for emergency medical treatment to be given to myself if necessary, in absence of family or next of kin.
- I authorize WA Health Group when required, to invoke the Freedom of Information Laws to access information that may be useful and relevant in assisting me with the services that WA Health Group provides.
- I consent to being placed on the WA Health Group contact list so that I can be kept informed of current events and information relating to the program and WA Health Group via electronic as well as standard means of communication.

PLEASE NOTE:

1. WA Health Group may give parents/guardians/ next of kin a copy of official reports and documentation, which client/parents/guardians may forward to relevant service providers.
2. As per policy guidelines of the Commonwealth of Australia's Privacy Laws, any information released or received by WA Health Group will be treated with the strictest of confidence and will not be shared with an external party except in circumstances where your written permission has been obtained; where required by a court of law; or when failure to disclose information would place you or another person at serious or imminent risk.

I have read and fully understand all of the above.

DATE: _____

NAME: _____

PATIENT SIGNATURE: _____