General Assessment Form

Name	
Date of Birth	Phone
Postcode	Ref

Your Name			Today's date
Date of Birth	Age	Gender ☐ M ☐ F	MRN (office use)
Street Address		Suburb	
State	Post Code	Home Phone	
Mobile		Work Phone	
Preferred contact method	☐ Text ☐ Email ☐ Phone		
Please write the contact details for a person in case of emergency			
Name		Relationship	
Contact Phone	Address		

Please write your insurance details.			
Medicare No.		Expiry date /20	EPHC ☐ Yes ☐ No
DVA Card	☐ Yes ☐ No	Pension Card No.	
Health Fund Name	☐ Yes ☐ No	Member No.	Extra Cover ☐ Yes ☐ No
Workers Comp or Third Party	☐ Yes ☐ No	Insurance Company	Claim No.
Insurance Address/phone		Contact Person	
Additional Information	Office use only		

Will you indicate your permission for the actions below?	
Do we have permission to text ☐ email ☐ you about your appointments?	☐ Yes ☐ No ☐ N/A
Do we have permission to call you at your work number if provided?	☐ Yes ☐ No ☐ N/A
From time to time data collected is used for research and clinical statistical purposes. Do you consent to your data which will be de-identified to be used for lymphoedema patient registry or research purposes? If Yes, please sign.	☐ Yes ☐ No Signature

Your referral information				
How did you hear about our service?				
Do you have a referral?		☐ Yes ☐ No	Name of Referrer	
Your Doctor's Details	GP	Name/Address/Phone		
	Specialist	Name/Address/Phone		
Is an interpreter required?		☐ Yes ☐ No	If Yes, what language?	Details
Do you have a current lymphoedema therapist?		☐ Yes ☐ No	Name	
Email address				Contact Phone
Address				

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QUESTIONS ABOUT YOUR WORK, ACCOMMODATION AND CARE NEEDS	
Occupation:	☐ full time ☐ part time ☐ casual ☐ retired ☐ unemployed
What type of accommodation do you reside in?	☐ House/unit ☐ retirement village ☐ hostel ☐ nursing home
Do you require support for personal care?	☐ Yes ☐ No Details:

QUESTIONS ABOUT YOUR GENERAL HEALTH AND ACTIVITY			
Do you have any of the following conditions? (Please tick boxes)			
☐ Heart condition	☐ High blood pressure	☐ Low blood pressure	☐ Venous disorder ☐ Arterial disorder
☐ Diabetes	☐ Epilepsy or Neurological disorder	☐ Infectious disease	☐ Kidney problems
☐ Osteoporosis	☐ Cancer (under active treatment)	☐ Cancer (stable, no active treatment)	☐ Pain acute/chronic
☐ Asthma	☐ Chronic lung disease	☐ Depression	☐ Anxiety
☐ Pacemaker	☐ Metal Implants	☐ Portacath	☐ Visual Impairment
☐ Hearing impairment	☐ Currently smoking	☐ Fall in last 12 months	☐ Currently pregnant
Do you have any other health concerns?			
How would you describe your usual physical activity and mobility levels? ***Tick the most accurate response on each line below.***			
☐ High intensity	☐ Moderate intensity	☐ Light intensity	☐ Sedentary
☐ Walks unaided	☐ Assisted: stick or frame	☐ Wheelchair	☐ Bed bound
☐ Arm/Upper body movement	☐ Full movement	☐ Limited movement	☐ No movement
Has your usual physical activity changed in the last three months?		☐ Yes ☐ No	
If Yes, why?			

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Australasian Lymphology Association

Excellence in lymphoedema management, research & education

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YOUR EXPECTATIONS
What has prompted you to visit this practice/clinic?
Details
What would you like to achieve by attending this practice/clinic?
Details

YOUR RIGHTS
This clinic/practice has a policy for handling your personal information which complies with National Privacy Legislation. If you would like further information please ask reception staff or your treating therapist. This clinic/practice adheres to the Australian Charter of Health Care Rights or the New Zealand Code of Healthcare and Disability Services Consumers Rights (2009) You have the right to request the therapist of your choice. You have the right to seek a second opinion regarding any advice or treatment you receive at our clinic. You may refuse treatment and/or the clinic's ongoing involvement in your care You are welcome to provide the clinic with feedback/compliments/complaints. If you wish to do this the reception staff will provide you with information regarding this procedure.
I confirm that the above information is correct to the best of my knowledge.

Name	Signature	Date
Therapist Name	Signature	Date

THERAPIST USE

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