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Welcome to ITH this is the first step on your path to wellness and we look forward to meeting with you in person.

We have created this comprehensive intake form for you to fill out in advance of coming to see us. We realise it might take some time for you to go through, but this will give you an opportunity to think and remember about your past medical history, about your current medical concerns and reasons for seeking our help. Having all this information on paper will be very helpful when you come in, and we will review this together during your medical or nutritional consultation. We have learned that it is often hard for our patients to remember everything when sitting in front of us!

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| **Patient Information** Miss Master (Please circle one) | | | | | | | | | |
| Name: | | | | | | | | Date: | |
| Age: | | | DOB: | | | | | Gender: | |
| Occupation: | | | | | | | | | |
| Address Details: | | | | | | | | | |
| Street No. and Name: | | | | | | | | | |
| Suburb: | | State: | | | | Postcode: | | | |
| Home Phone: | | | | | | | | | |
| Mobile Phone: | | | | | Work Phone: | | | | |
| Email Address: | | | | | | | | | |
| Permission to leave a message on your answering machine or send an SMS: Yes  No | | | | | | | | | |
| Emergency Contact Name: | | | | | Relationship: | | | | |
| Emergency Contact Phone Number: | | | | | | | | | |
| Next of Kin: | | | | | Relationship | | | | |
| Next of Kin Contact Phone Number: | | | | | | | | | |
| **Medicare Number:** | | | | **Position Number:** | | | **Medicare Expiry Date:** | | |
| Pension/Health Care Card Number: | | | | Health Care Card  Expiry Date: | | | | | Pensioner: Yes/No |
| Preferred Method of contact to confirm appointments:  SMS to Mobile phone:  Message left on answering machine:  **to help the practice provide appropriate health care, are you of aboriginal or torres strait islander origin?**  aboriginal  neither aboriginal or torres strait islander  Torres Strait Islander  both aboriginal & Torres Strait Islander | | | | | | | | | |
| **PATIENT CONSENT Circle if applicable only**  **I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Parent/Guardian)** understand that the information given to my treating doctor/therapist during my consultation is recorded by the doctor/therapist in my medical file. I give permission for information in my file to be forwarded to other medical persons if it is seen to be necessary for my health. I understand that all information in my file can only be accessed in agreement with my treating doctor on the basis that confidentiality and protection of privacy is assured.  Signed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date: ­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | |
| **How did you find out about Invitation to Health?**  Invitation to Health Facebook Page Google/other search engine  Magazine/Newspaper  Our Email/Newsletter Communication  Our Website  Word of Mouth  Practitioner referral | | | | | | | | | | |
| date | condition/reason | | | | | | | | | |
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| **Fully immunised:**  YES  NO  **Please list any vaccines not received:** | | | | | | | | | | |
|  | | | | | | | | | | |
|  | | | | | | | | | | |
| |  | | --- | | **Past Medical History** | | Check box if you have been diagnosed with any of the conditions below, either presently or in the past (prior to 6 months) | | **GASTROINTESTINAL CARDIOVASCULAR METABOLIC/ENDOCRINE**  IRRITABLE BOWEL SYNDROME  rheumatic fever  INSULIN RESISTANCE  INFLAMMATORY BOWEL DISEASE  other   HYPOTHYROIDISM (LOW THYROID)  pEPTIC ULCER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  HYPERTHYROIDISM (OVERACTIVE)  gord (REFLUX)   bulimia  coeliac disease **skin diseases**  anorexia  colonoscopy  eczema   binge eating disorder  when ­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  psoriasis   type 1 diabetes  other  acne  other  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   other \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **inflammatory/ neurologic/mood**  **autoimmune**  depression  glandular fever  anxiety  rheumatoid arthritis  headaches  lupus/sle  migraines  immune deficiency disease  add/adhd  food allergies  autism  environment allergies  seizures  multiple chemical sensitivities  other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  latex allergy  other autoimmune  **respiratory diseases**  asthma  **genital and urinary**  chronic sinusitis  frequent urinary tract   bronchitis  infections   pneumonia  frequent yeast infections   tuberculosis  sleep apnoea  other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **musculoskeletal or p****AIN**    chronic pain  other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | **Further Medical History** | | **your childhood history dental history**  lots of sugar as a child  lots of cavities as a child  ear infections  silver mercury fillings  recurrent strep throat how many? \_\_\_\_\_\_\_\_  lots of antibiotics  gold fillings  bleeding gums  stomach aches  root canals  gingivitis  other childhood illnesses  implants  floss regularly  tooth pain |   **Family History** Family history - have any members of your family had: Diabetes  Depression  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Asthma  Stroke  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Heart Disease  Cancer - Type  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Mental illness  Smoker  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Other | | | | | | | | | | |

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| **Social & Personal History** (tick all that apply) | | |
| **ethnicity**: australia is a genuinely multicultural society. to tailor appropriate care, encourage understanding and appreciation between people from different nationalities and backgrounds – do you identify as someone from a culturally and /or linguistic diverse background?  Yes  No | | |
| **If Yes, please give detail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | |
| **sleep**  How many hours sleep does your child have at night? ­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  what time does he/she go to bed? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ wake up? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  does he/she have issues settling to sleep? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  does he/she have issues with waking through the night? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Do you co sleep with your child often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| **Exercise – Does your child participate in activities outside of school?** | | | |
| activity | type | how often each week | |
|  | | | |
|  | | | |
|  | | | |
| **Environmental or Other Exposures and Detox Assessment** | | | |
| history of:  adverse reaction to:  jaundice (turning yellow)  gilbert’s syndrome or a liver disorder  monosodium glutamate (MSG) explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  aspartame (nutrasweet)  bananas  garlic  onion  cheese exposure to harmful chemcials such as:  citrus foods  chocolate  herbicides  sulphite containing foods  insecticides (frequent visits of exterminator)  (dried fruit, salad bars)   pesticides  preservatives (sodium benzoate)  organic solvents  other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  heavy metals  other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_      chemical name/date/length of exposure  dry clean your clothes frequently  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  lived in a damp or mouldy  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ environment or had other mould exposure  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  do you have any pets or farm animals  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  electromagnetic radiation  work with oil based paint - artist or painter  home enVIRONMENT, are you exposed to:  chemicals  mould | | | |
| **Current Health Reason for this Visit?** Tick all that apply  General health, prevention and wellbeing  Chronic illness/condition (heart disease, diabetes, chronic pain of > 3 months etc)  specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Acute illness – specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Surgery-related – specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Other – specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |

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| **What type of Service are you here for?** (Check all that apply)  GP Consult  Biomedical Consult  Nurse Consult  Traditional Chinese Medicine  Acupuncture  Osteopathy  Kinesiology  Psychology  Nutrition  Naturopathy  Bach Flowers  Other |
| **Medical History** |
| What brings you to Invitation to Health? |
|  |
| If you had 3 wishes for your visit today, what would they be? |
|  |

**SYMPTOM REVIEW –** Please tick if you have any of the following symptoms:

**sKIN pROBLEMS** **hEAD, EYES & EARS** **CARDIOVASCULAR**

Acne  Distorted Smell  CHest Pain

Athlete’s foot  distorted taste  Breathlessness

bumps back of arms  bad breath  palpitations

cellulite  ear fullness  pain in calves

dandruff  ear pain  swollen ankles

dark circles under eyes  ear ringing  varicose veins

ears get red  hearing problems  LIGHT HEADEDNESS

RECURRENT SORE THROAT  FAINTING

HOARSENESS

easy bruising  eye pain/IRRITATION **respiratory**

eczema  vision disturbance  snoring

sinus  cough

cold sores  migraine  coughing up blood

hives  headache  hayfever

noise sensitive  sinus fullness

change in moles  jaw pain  nasal stuffiness

oily skin **nails**  nose bleeds

psioriasis  bitten  post nasal drip

rash  brittle  SHORTNESS of breath

sensitive to bites  fungus  at rest

shingles  ridges  with exercise

skin itching  thickened

skin drynress  white spots/lines

strong body odour

**DIGESTION MUSCLE/BONE ENDOCRINE/IMMUNE**

BLOATING AFTER EATING  MUSCLE TWITCHING  COLD HANDS/FEET

BLOOD IN STOOLS  MUSCLE PAIN  COLD/HEAT INTOLERANCE

BURPING  JOINT PAIN OR SWELLING  FATIGUE

CONSTIPATION  JOINT STIFFNESS  WEIGHT GAIN

ANAL ITCHING  BACK PAIN  GET SICK A LOT

TROUBLE CHEWING **MOOD/NERVES**  SWOLLEN LYMPH NODES

DIARRHEA  DIFFICULTY CONCENTRATING  HAIR LOSS

DIFFICULTY SWALLOWING/PAINFUL  DIFFICULTY WITH BALANCE **URINARY**

DRY MOUTH  DIFFICULTY WITH JUDGEMENT  HESITANCY

FISSURES  DIFFICULTY WITH MEMORY  FREQUENT uti

HEARTBURN (REFLUX)  DIZZINESS (SPINNING)  PAIN/BURNING

HAEMORRHOIDS  SUICIDAL THOUGHTS  URGENCY

**INTOLERANCE TO**:  depression  LEAKING

LACTOSE  NUMBNESS  BLOOD IN URINE

ALL MILK PRODUCTS  panic attacks

GLUTEN  anxiety

CORN  OTHER PHOBIAS

EGGS  PARANOIA

fatty foods  HALLUCINATIONS

Other ­­­­­­Click here to enter tex  SEIZURES

TREMOR

**SYMPTOM REVIEW continued –** Please tick if you have any of the following symptoms:

yellow eyes/skin

ABDOMINAL PAIN

MUCOUS IN STOOLS

NAUSEA

STRONG STOOL ODOR

UNDIGESTED FOODS IN STOOLS

VOMITING

UNINTENTIONAL WEIGHT LOSS

CAR SICKNESS

|  |  |
| --- | --- |
| **Nutrition and Diet** | |
| nutrition history  have you ever had a nutrition consultation?  yes  no  Was/is this child breastfed?  yes  no  for how long? ­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Did you use formula?  yes  no  if so what type? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Did you have to change formulas to get the right one? if so please give details:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Does your child follow any special diet?   yes  no    describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Does the whole family follow this way of eating?   yes  no  do you have any concerns about your childs diet?  yes  no  PLEASE EXPLAIN YOUR CONCERNS (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  how often does your child have a bowel movement? (if known)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  is your child’s diet high in junk food and/or take-away?  yes  no  do you read food labels?  yes  no \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  do you cook?  yes  no, if no who does the cooking? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  how much water does your child drink every day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  CHECK ALL THE FACTORS THAT APPLY TO YOUR CURRENT LIFESTYLE AND EATING HABITS:  FAST EATER  ERRACTIC EATING PATTERNS  EAT TOO MUCH  LATE NIGHT EATING  DISLIKE HEALTHY FOOD  TIME CONSTRAINTS  NON AVAILABILITY OF HEALTHY FOODS   POOR SNACK CHOICES  EAT TOO MUCH UNDER STRESS  EAT TOO LITTLE UNDER STRESS  RELIANCE ON CONVENIENCE ITEMS  FAMILY MEMBERS DON’T LIKE HEALTHY FOODS  FAMILY MEMBERS HAVE SPECIAL DIETARY NEEDS OR FOOD PREFERENCES  LOVE TO EAT  only EATs BECAUSE he/she HAs TO  HAs A NEGATIVE RELATIONSHIP WITH FOOD  STRUGGLE WITH EATING ISSUES  EMOTIONAL EATER (EAT WHEN SAD, lonely, depressed)  eat in the middle of the night | |
| **Nutritional Supplements (vitamins, herbs, homeopathy)**  **\*PLEASE BRING ALL YOUR SUPPLEMENTS/MEDICATIONS TO YOUR FIRST APPOINTMENT\*** | |
| supplement/brand | Reason for use |
|  |  |
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| **Readiness to Change** | |

**OUR PRACTICE IS SCENT-FREE**.

*The chemicals used in scented products can make some people sick, especially those with fragrance sensitivities, asthma, allergies and other medical conditions.*

***Please Do Not Wear Perfume or Heavily Scented Body Care Products When Attending This Surgery***

**APPOINTMENT CONFIRMATION & CANCELLATION POLICIES**

Effective from the 16th February, 2021

Invitation to Health advises we have implemented new policies for Appointment Reminders and Confirmation of Appointments to maximise doctor and practitioner availability for our patients.

**PAYMENT POLICY**

\* Please note this applies to all integrative GPs.

For new patients: At the time of booking your first appointment, your credit card details will be taken and the amount of the consultation fee held against your card for a period of 10-15 days (depending on your card provider) as a guarantee for your scheduled appointment. At the end of this period, the funds shall be released back to you until the day of your appointment, and your card information will be held and utilised in the event of cancellation or non-arrival fees.

**APPOINTMENT CANCELLATION POLICY**

\* Please note this applies to all GPs & all therapists.

All appointment cancellations are required to be made a **minimum of 2 BUSINESS DAYS** prior to your appointment to avoid the **full consultation fee**. ie: If your appointment is scheduled on a Monday, notice to cancel is required by 5pm Thursday of the week prior. This includes “No Shows”. **The** **full consult fee will be debited from the credit card stored** and no future appointments shall be made until the cancellation fee has been paid.

**TEST RESULTS**

\* Please note this applies to all GPs & all therapists

When patients are referred for testing, it is a requirement that a follow-up consultation is made to discuss results. Results will not be provided without consultation with the referring practitioner. After discussing the results you can request copies for your own records.

**SMS REMINDER POLICY**

\* Please note this applies to all appointments within our practice.

**5 days** – A reminder text message will be sent to you 5 days prior to your appointment. Please reply to confirm your appointment or call Reception to reschedule. **Failure to reply prior to 2 BUSINESS DAYS**  **in advance of your appointment will result in your appointment being cancelled** and offered to patients on our waiting list. **The** **full consultation fee will be debited from the credit card on file.**

**24 Hours** – A second reminder SMS will be sent 24 hours prior to your appointment as a reminder (no response required).

All patients without mobile phones will be contacted at the same intervals on their landline.

Please sign to acknowledge the above policies.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_