Michael A Murphy
EAST MELBOURNE NEUROSURGERY

Neurosurgeon

Dear Sir/Madam

Attached are four forms to fill in. **All** forms must be filled in and signed prior to your consultation or your appointment may need to be rebooked.

Yours faithfully

Michelle
Practice Manager

FRACS Fellow of the Royal Australasian College of Surgeons

Associate Professor Michael A Murphy
Level 5, 182 Victoria Parade, East Melbourne, VIC, 3002
Phone: 9663 5399 Fax: 9663 5299
email:info@emns.com.au
web:www.drmichaelmurphy.com.au

Confidential Patient Registration Details

Mr, Mrs, Ms, Miss, Dr

Surname.....Given Name(s).....

Address.....

Suburb.....Post Code.....

Telephone: Home.....Business..... Mobile…….

Date of birth.....Age.....Marital Status.....

Occupation..... Next of Kin: .....Contact no.....…….....

Email.....Skype.....

Referring doctor (Name, Address) .....

Local Doctor Name and address (if different from above)

.....…….

Name and address of any other doctor you wish to be informed of your condition

.....…….....

Medicare Number..... Card Ref. No. (Adjacent to your name) ……Valid to…….

Private Health Insurance: YES / NO If Yes, Fund name.....….....Level.....……

Membership No:…… Year Joined…….....

Veteran Affairs Card Holder YES / NO If Yes, Gold or White, number:……

Pension Card Holder YES / NO If Yes, Type (Age, Disabled, etc)……..

Ambulance Cover: YES / NO Member No: .....

How did you hear about A/Prof Murphy (internet, GP, specialist, friend, etc) ……..

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Signature Date

Complete all of the following details *(circle correct reply)*

Do you smoke? YES / NO / PREVIOUS

Do you consume alcohol? YES / NO If YES, how much?

Do you suffer from any of the following:

High blood pressure	YES / NO
Diabetes	YES / NO
Heart disease	YES / NO
Stomach complaints	YES / NO
Other major illness	YES / NO

If YES, please specify …….....

Are you allergic to any medications? YES / NO

If YES, please specify ……..

……..

Are you currently taking any medications? YES / NO

If YES, please state name, dose and the reason for taking these tablets (e.g. high blood pressure)

Name	Dose	Reason for taking
……		
……		
……		
……		
……		

Have you ever had an operation: YES / NO If YES, please specify?

…….....
……
.....
.....

The following outlines the fee schedule charged by this Practice

(Effective 1st October 2015)

Please read carefully as this page must be signed prior to your consultation.

Consultation

Initial Consultation $300
Subsequent Consultations $150
Extended Consultation $190

If you have surgery performed privately, your initial postoperative review is covered by "aftercare". Following that, the usual review appointment fee of $150 or $190 will apply.

Operation

If you require an operation, then you may elect to have this through the public or the private system. If it is through the public system you will be placed on the waiting list, your condition categorized according to the Department of Human Services guidelines (relates to urgency of your condition) and contacted by St Vincent's Public Hospital when there is a bed available. Your operation will be performed by one of the neurosurgical team and no guarantee can be given as to whom this will be.

If you elect to have your surgery through the private system, this will be performed at St Vincent's Private Hospital and A/Prof Michael Murphy will perform the surgery. You will usually be given an admission date shortly after your decision to have surgery.

There is an out of pocket cost for surgery, which will be discussed at consultation and confirmed in writing. If you are admitted at short notice or as an emergency, then it may not be possible to supply a written estimate of "out of pocket expenses".

Completion of forms

Any forms that are required to be completed by A/Prof Murphy, with the exception of transport forms, will incur a fee. This fee is required to be paid prior to completion.

Please sign below that you understand and agree to the terms and conditions outlined above.

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Signature ***Print Name*** ***Date***

DECLARATION

This page must be signed prior to your consultation

Dear Associate Professor Murphy,

I confirm and declare that when I initially made this booking I informed your office that the condition for which I wished to see you was not related to, or potentially related to:

- a motor vehicle accident;
- a worker's compensation claim; nor
- any other claim where a third party may be involved.

In signing this form I confirm that the above information is correct and true and is a condition of your agreement to see me as a patient.

Signature: _____ Name: _____

Date: _____/_____/_____