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PATIENT REGISTRATION FORM

Please complete form and return via email prior to your appointment

Personal details		
Surname:	First Name:	
Date of birth:	Preferred pronouns:	
Address:		
Suburb:	Postcode:	
Contact number:	Email:	
Medicare card number:	Number beside name:	Medicare expiry date:
Private health fund:	Membership number:	
Have you registered with Medicare On	iline claiming? Yes No	
I hereby authorise Dr Nicole Hope to r	release any results to my partner:	
Signature	Print full name	Date (DD/MM/YYYY)
Partner's details (if applicable)		
Surname:	First Name:	
Date of birth:	Preferred pronouns:	
Address:		
Suburb:	Postcode:	
Contact number:	Email:	
Medicare card number:	Number beside name:	Medicare expiry date:
Private health fund:	Membership number:	
Have you registered with Medicare On	lline claiming? Yes No	
I hereby authorise Dr Nicole Hope to r	elease any results to my partner:	
Partner's Signature	Print full name	Date (DD/MM/YYYY)
Do you wish to have reproduct	ive Genetic Carrier Screening (GCS)?	
	_	de la deservació de la transportación de la consequención de la co
such as Cystic Fibrosis (CF), Fragile X S one in their family has the condition. T detect every person who is a carrier. I	est that gives individuals and couples information about to Syndrome (FXS) and Spinal Muscular Atrophy (SMA). Pec The screening test will identify about 90% of people who to it is possible to test one partner first. If an abnormal geresults take approximately 10 working days to be processed.	ople can be carriers of CF, FXS or SMA even if no o are carriers of CF, FXS or SMA. The test will no ne is identified, it may be recommended for the
Medicare will BULK BILL standard GCS		
Do you consent to the standard GCS to	est? Yes No	
Expanded GCS (tests for 289 to >500 g Would you like to discuss this further?		