Step 1) Print this form.
Step 2) Complete the form and sign it.
Step 3) Email this form and your referral to: **lisa@ianeveritt.com.au**

Dr Ian Everitt
CONSULTANT PAEDIATRICIAN

CHILD'S DETAILS

Miss/Master (Please circle)

Surname/Family Name:________________________________First Name:___________________________

Date of Birth:_________ / _________ / __________Obstetrician:______________________________________

Medicare Card Number:____REF:____EXPIRY:______ /______

PARENT'S DETAILS

Mother's Full Name: Miss/Ms/Mrs____

Mother's Date of Birth:____/_____/_____ Father's Name: ____

Address:____

Suburb:_____________________________________State:____________________Post Code___________

Phone Number:__________________________Mobile Number:___________________________________

I consent to receive SMS text appointment reminders ❒Yes ❒No

Mums Medicare Card Number:_____________________________________REF:_______EXPIRY:____ /____

Email: ____

GP DETAILS:

GP Name:_______________________________________Phone Number:____________________________

GP Practice Name:______________________________Address: ___________________________________

Any other information you think the doctor should know:____

CONSENT:

I consent to the use of my personal health information by Dr Ian Everitt and other health care providers involved in my medical treatment and health care within this centre.

I consent to the disclosure of my personal health information by the above named doctor to other health care providers involved directly or indirectly in my personal health care or medical treatment.

Signature: ____ **Date:** ___________________________

Printed Name: ____