DR VIRGINIA OLIVEIRA
Consultant Paediatrician / Sleep Medicine
MBBS, FRACP
Provider No: 299534BA

THE SLEEP COTTAGE
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NEW PATIENT FORM

Surname of child: _____

Given Names: _____

Known as: _____

DOB: ____/____/_____ **Gender: Male / Female / prefer not to say / Other** _____

Aboriginal / Torres Strait origin? Yes / No / prefer not to say

Address: _____

_____ **Post Code:** _____

***Mobile:**_____ **Home Phone:** _____
(*This mobile will be used for SMS confirmation of appointments)

E-mail: _____

Parent 1 Surname:_____**Given Names:** _____

***Parent 1 DOB:**____/____/_____*(*required for Medicare electronic identification)* **One parent on form is OK**

Title: Mr / Mrs / Ms / Dr / Other:_____**Relationship to child:** _____

Parent 2 Surname:_____**Given Names:** _____

***Parent 2 DOB:**____/____/_____ **Parent 2 Mobile:** _____

Title: Mr / Mrs / Ms / Dr / Other:_____**Relationship to child:** _____

Parent 2 E-mail: _____

Medicare Number:_____ _____ ___ **Expiry:**_____/_____

Medicare card reference Number - Child: _____ **Parent 1:** _____ **Parent 2:** _____

If Parent has different Medicare card to child

Number:_____ _____ ___ **Expiry:**_____/_____ **Ref No:**_____

CONSENT FORM

While we take every reasonable step to safeguard your details, we may disclose confidential information regarding your child under the following circumstances:

- With your direct consent;
- If there is an immediate and specific risk of harm to the child / to others;
- Where there is a legal obligation to do so, such as harm to oneself, harm to others, child neglect/abuse, or mandatory reporting; and
- When consulting colleagues, or in the course of professional supervision.

***Important note: This practice uses encrypted audio captured during consultations for AI-generated patient letters and reports.**

I _____parent/ carer of _____ consent to the collection for this practice and release of all necessary and pertinent information regarding this patient to the following parties (*Provide Name, Suburb & Phone Number below*):

- **General Practitioner _____**
- **Paediatrician _____**
- **Specialist _____**
- **Allied Health Professionals:**

  Speech pathologist _____

  Occupational therapist _____

  Psychologist _____
- **Other _____**
- **School / Preschool _____**
- **Day Care _____**

FINANCIAL CONSENT and CANCELLATION FEES

By signing below, I understand and agree that if I give less than 48 hours' notice of cancellation, or do not attend a confirmed appointment or sleep study there will be a cancellation fee issued to me equal to the fee of the consult that is cancelled or missed ($250-$650).

This fee must be paid before any further appointments will be made.

Name:_____ Date: _____

Signature: _____