

**PATIENT/MEMBER INFORMATION**

Customer Number	Patient Name	Date of Birth (dd/mm/yyyy)
Preferred Email Address for Response		

**DECLARATION**

I consent to the disclosure of my medical information relating to the condition(s) requiring hospital treatment to health.com.au. I also give consent for any other medical practitioner(s) who has/have seen me regarding the condition(s) to give medical information to health.com.au.

Signature of Patient (or Guardian)	Date (dd/mm/yyyy)
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**DETAILS OF NEW DEVICE**

Name of Device	Model Number	Proposed Date of Implant (dd/mm/yyyy)	
AHSA Prosthesis List Rebate Code		AHSA Prosthesis List Benefit	
Will an Admission be Required? If so, where?			
Date Diagnosed with Type 1 Diabetes (dd/mm/yyyy)	Current Form of Insulin Delivery	HBA1C Reading	Frequency of Testing

**ENDOCRINOLOGIST DETAILS**

Name of Endocrinologist	Date Started Seeing Patient (dd/mm/yyyy)
Telephone Number (include area code)	Email Address
Date (dd/mm/yyyy)	Signature

**DIABETES EDUCATOR DETAILS**

Name of Diabetes Educator	Date Started Seeing Patient (dd/mm/yyyy)
Telephone Number (include area code)	Email Address
Date (dd/mm/yyyy)	Signature

**Please return this form to health.com.au - ATTENTION: HOSPITAL TEAM - via one of the methods below:**

Email: [customers@health.com.au](mailto:customers@health.com.au)

Fax: 03 8609 1396