SCREENING CONSULTATION FORM

nexus Primary Health

living well in your community

Given Name		**Surname**			
DOB		**Gender**		**Indigenous Status**	
Medicare card details	1234 56789	**Issue**	9	**Ref**	9
Patient Address					
		State		**Postcode**	
Mobile Number	0499 999 999	**Phone Number**	03 9999 9999		

Emergency Contact Details			
Name		**Relationship**	
Mobile number	0499 999 999	**Phone Number**	03 9999 9999

Regular GP Name		**Phone Number**	03 9999 9999
Regular GP Address			

What is your occupation?	Do you have any of the following symptoms?	Do you any of the following apply to you?
☐ Health Care ☐ Aged Care ☐ School Education ☐ Child Care ☐ Disability Care ☐ Other: (specify) _____	☐ Fever ☐ Cough / Shortness of breath ☐ Sore throat ☐ Fatigue / Tiredness ☐ Stuffy / Runny nose ☐ Stomach upset ☐ Other: (specify) _____	☐ Heart Disease ☐ High Blood Pressure ☐ Diabetes ☐ Pregnant ☐ Lung Disease (inc Asthma) ☐ Smoker ☐ None of the above

Allergies	Specify or write Nil Known

Interstate or International travel in 14 days prior to symptom onset?	yes/no
Contact with confirmed/known case in 14 days prior to symptom onset?	yes/no

☐ **I confirm the patient has consented to the collection of the above details and has access to the nexus primary health privacy statement and policy related to the safe and lawful storage of any medical records**