dr. michael flynn
women's health fertility - IVF pregnancy

Dr Michael Flynn
MBBS (QLD) FRANZCOG FRCOG
Obstetrician, Gynaecologist, Infertility IVF

Have you attended this practice before? :			
First name: Title:	Middle name:		Surname:
Address:			
Postal address:			
DOB:	Home Ph:	Mobile Ph:	Work Ph:
Email:		Occupation:	
Medicare No:		Ref No:	Expiry date:
Name of Health Fund:	Member No:	Ref No:	Member for more than 12 months? :
Vet Affairs No:		Are you an Australian resident?:	
Partner / next of kin name:	Partners DOB if relevant:		
Partner / next of kin phone no:	Mobile ph no:		
Please nominate one person who can ring on your behalf for results etc.			
Disclosure to:	Relationship:	Phone No:	

I hereby consent to necessary examinations and to Dr Flynn using the collected personal and health information in accordance with the privacy act. I authorise Dr Flynn to access/disclose my health information from my referring Doctor/Medical Specialists, allied health practitioners and institutions who may require information about my medical history but only to the extent necessary to access/treat the particular condition. I also understand that this appointment may involve pelvic or vaginal examination and transvaginal ultrasound and I hereby consent to such examination.
I also understand that pathology or other examinations may be required by another company and therefore, they may charge me for their services.

Signed: **Date:**

dr. michael flynn
women's health fertility - IVF pregnancy

New Patient Medical History Form

Name		Date of Birth	
Please list any medications you are currently taking.			
Please list any allergies you have.			
Please list any past surgical procedures you have undergone.			
Please list any medical conditions you have.			
Please list any significant family history.			
Please list any previous pregnancies.			
Have you had any recent ultrasound or scans?		Date: Which company?	
Have you had any recent blood tests?		Date: Which pathology company?	
When was your last pap smear and have you had any abnormal smears?			
If you are pregnant and blood group negative – you will be given Anti D in pregnancy. This is a blood product.		Please sign_____ (write n/a if you are not pregnant).	

The information you provide will be treated as confidential and used to assist Dr Flynn at your consultation.

dr. michael flynn

women's health fertility - IVF pregnancy

Due to privacy laws, we now require written consent to forward any information with sensitive information on it via email. This may include operation quotes, work certificates, and other matters.

If you consent to us sending this information, could you please sign this form.

PLEASE NOTE: This is only valid for 12 months.

Email Authorisation

I,.....

DOB: .....

give permission to receive information (which may include details of any surgical procedures or other treatments) from Dr Flynn's office to the following email address:

.....

This is my personal email address, and not a work email address.

Signed:.....

Date:.....