FertilityNorth
Fertility & Endometriosis Treatment Centre
GynaeNorth

CLERICAL INFORMATION SHEET

DATE

*Denotes mandatory field	Female Patient Information	Partner Information ☐ N/A
	Please ensure that your name on this form MATCHES the name stated on your Medicare card	
File Number *(office use only)*		
Title *(Miss/Mr/Mrs/Ms)*		
* Surname		
* Given Names(s)		
Preferred Name *(if applicable)*		
Previous Surname *(if applicable)*		
* Date of Birth		
Country of Birth		
* Street Address		
* Suburb		
* Post Code		
Home Telephone		
Work Telephone		
* Mobile Telephone		
* Email Address		
Occupation		
Marital Status *Please tick applicable*	☐ Married ☐ De Facto ☐ Single	

Medicare Number				
Medicare Reference #		Expiry		Expiry
Private Hospital Cover? *(Not ancillary or extras cover)* *Please tick applicable*	☐ Yes, I have Private Hospital Cover ☐ No, I do not have Private Hospital Cover		☐ Yes, I have Private Hospital Cover ☐ No, I do not have Private Hospital Cover	
If yes, have you had this private hospital cover for more than 12 months? *Please tick applicable*	☐ Yes (Name of fund _____) ☐ No		☐ Yes (Name of fund _____) ☐ No	
If yes, Private Health Fund Membership Number				

Have you been hospitalised outside Western Australia in the past 12 months? *Please tick applicable*	☐ Yes	☐ No	☐ Yes	☐ No
If yes, Nasal Swab?	☐ Negative	☐ Positive	☐ Negative	☐ Positive

Name of Referring Doctor		Date of Referral	
Address of Referring Doctor			