Professor RN Dunn

OrthoUCT
Orthopaedic Surgical Practice

Patient Information Sheet

Patient:

Surname: _____ First Names: _____

Address: _____

_____ Code: _____

Telephone: (H) _____ (W) _____ (C) _____

ID Number: _____

Date of Birth: _____

Email address: _____

Referring doctor: **Please give all details, if not given we cannot send a report**

Name: _____ Telephone: _____

Address: _____ Fax: _____

_____ Code: _____

Person responsible for the account if not the same as the patient.

Name: _____

Address: _____

_____

Telephone: (H) _____ (W) _____ (C) _____

ID Number: _____

Medical Aid: _____ Plan: _____

Number: _____ Gap cover _____

Email address: _____

Y / N My anonymoused clinical data may be used for research and medical teaching purposes

Y / N My anonymoused imaging may be used for research and medical teaching purposes

Y / N If I have surgery, the spine team may communicate with each other on a dedicated whatsapp group to coordinate inpatient care

I, the undersigned, accept responsibility for the consultation fee. I understand that settlement is due at the time of consultation and that my medical aid may not reimburse the fee in full.

Dated: …… Signature: ……