COUCH wellness centre

Registration Form

COUCH WELLNESS CENTRE CLIENT REGISTRATION FORM

Important Information:
The COUCH Wellness Centre provides a hub for health and well-being, it creates a space for people diagnosed and living with cancer to access services under the one roof and creates networks to other supportive services within the region.

In receiving care and services, you understand and acknowledge that the COUCH Wellness Centre:

- Will provide care coordination (nursing, allied health, complementary therapies by staff and contractors)
- Is not medically responsible for your treatment or any medical care. This remains the responsibility of your GP and/or treating team
- May arrange transport to a hospital in the event of a medical emergency

Our ***Care Partnership*** with you enables:

- Individual needs assessment and care planning by a cancer care nurse, including referrals, follow ups and reviews as required
- Subsidised consultations with COUCH Wellness Centre Allied Health and Complementary Therapists, including Medicare, Private Health
- Access to a variety of COUCH Wellness Centre supports and services for Carers at subsidised rates, including grief, loss and bereavement support
- Access to Support Groups, health and well-being classes, workshops and education events plus provision of the latest evidence and research in managing cancer as a chronic illness
- To nominate a carer/support person who is also welcome to access support groups, health and wellbeing classes and nursing support in regard to cancer care

For More Information visit www.couch.org.au or phone (07) 4032 0820.

If completing this form electronically, complete all fields and click the SUBMIT HERE button to send via email. Alternatively, send via fax to our client care team on (07) 4032 0498.

Client Name: _____

Registration Form

Client Details					
First Name:		Last Name:			
Preferred First Name:		D.O.B:		Age:	
Home Phone:		Mobile:			
Home Address:					
Email Address:					
Aboriginal or Torres Strait Islander?	☐Yes ☐No	Marital Status:	☐Single ☐Married ☐De-facto/ ☐Widowed	Title:	
Primary Language:		Interpreter:	☐Yes ☐No		

Health Services Cover and Eligibility				
Medicare Eligible:	☐Yes ☐No	Number:		Ref: Exp:
DVA Eligible:	☐White ☐Gold	Number:		
Private Health:	☐Yes ☐No	Fund Name:		
Membership Number:		Reference:		

Next of Kin Details			
First Name:		Last Name:	
Is this person your Primary Carer?	☐Yes ☐No	Relationship:	
Address:			
Direct Phone:		Email:	

Carer/Support/Family Member Details					
First Name:		Last Name:			
Preferred First Name:		D.O.B:		Age:	
Home Phone:		Mobile:			
Home Address:					
Email Address:					
Aboriginal or Torres Strait Islander?	☐Yes ☐No	Marital Status:	Single Married De-facto/Widowed	Title:	
Primary Language:		Interpreter:	☐Yes ☐No		

Client Name: _____

Registration Form

General Practitioner Details		Specialist or Treating Team Details	
Name:		Name:	
Practice/Facility:		Practice:	
Address:		Address:	
Direct Phone:		Phone:	

Care Partnership Program Terms and Conditions

Privacy notice:
Your personal information is protected by law (including the Privacy Act 1988) and is collected by the COUCH Wellness Centre for the purposes of the Care Partnership Program. Your information may be collected and stored for:

- Administrative purposes in the running of the COUCH Wellness centre, Medicare, Private Health and other ancillary funding agencies for billing purposes.
- Disclosure to other health professionals who are involved in your healthcare.
- Research and quality assurance activities to improve individual and community health care management. All information in this instance will be deidentified to comply with any legislative or regulatory requirements

Other information:
The COUCH Wellness Centre has CCTV security cameras recording, in most cases, 24 hours a day (except in clinical rooms and bathrooms) and may have remote video or other guarding services. This system is used for security purposes but does not guarantee against harm. You should contact us if you have questions on this.

Acknowledgement:

1. You acknowledge and recognise the inherent risks of injury or ill health resulting from use of the services and from participation in exercise generally. In consideration of participation in activities within the COUCH Wellness Centre, you agree to release and indemnify Cairns COUCH Ltd and any company associated with Cairns COUCH Ltd. You agree to participate in all activities at your own risk and responsibility whether supervised or not by personnel. You agree to release and hold harmless the personnel of the COUCH Wellness Centre and any associated parties from and against all actions which may be bought by you or on behalf of you in respect of any incident arising out of injury, loss, damage or death caused to you or your property in any way what so ever.

Please note: If you are under 18 years of age, you will need a Parent/Guardian to sign the consent form.

Client Name:		Carer/Support/Family Member Name:	
Signature:		Signature:	
Date:		Date:	

Client Name: _____

Registration Form

Medical Records Release Form (optional)

By signing this form, I authorise you to provide confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my health information, to COUCH Wellness Centre.

Client Name: **D.O.B:**

The information you may release, authorised by this signed release form, is as follows:

01. Past Medical History
02. Allergies
03. Medications
04. Oncology Treatment
05. _____
06. _____

Client to please note any exclusions or specific instruction:

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Patient's Signature

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Name of the Patient

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Date