

# Patient Referral Form



## YOUR CHILD'S DETAILS

First Name ..... Surname .....

Date of Birth ..... | ..... | ..... Gender Male | Female | Other (*Please circle*)

Address .....

..... Postcode .....

Medicare Number ..... Ref no. .... | Exp Date .....

Private Health Fund ..... Membership no. .... Ref no. ....  
Membership since .....

Please circle: Hospital Only | Extra Only | Hospital and Extras General Practitioner .....

Practice name and Address .....

Does your child identify as Aboriginal or Torres Strait Islander? Yes ☐ No ☐

Language spoken at home (*if not English*) ..... Do you require an interpreter? ☐

Does your child have a current NDIS Plan? ☐ Self-Managed | Plan Managed | Agency Managed (*circle*)

Are there any current or pending court orders in place? ☐ Please chat with our friendly reception staff

## PARENT | CARER'S DETAILS

**(Nominated Account Holder | Person to Receive Medicare Rebates)**

**NOTE:** If you require the account holder details to be changed for Medicare purposes, please ensure you notify our friendly reception staff prior to your appointment or payment. It is the **responsibility of the parent** to inform staff if a change to the account holder's details is needed – whether for a specific date or for all future services.

Please be aware that once a Medicare claim has been submitted **the account holder's name/details are unable to be changed.**

First Name & Surname ..... Date of Birth ..... | ..... | .....

Medicare Number (*if different than above*) ..... Ref no. ....

Relationship to Child ..... Phone Number ..... Email Address: .....

**PLEASE TURN OVER**

**PARENT | CARER or EMERGENCY CONTACT (if different)**

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First Name & Surname ..... Date of Birth ..... | ..... | .....  
Medicare Number (if different than above) ..... Ref no. ....  
Relationship to Child ..... Phone Number ..... Email Address: .....

Do you consent to SAPAN discussing your child's appointment and/or confidential information with this person? ☐

**Please Note:** This is a private specialist practice, and private fees will apply. We kindly ask for **full payment** at the conclusion of your appointment. Payment can be made by credit card or cash. Please be aware that merchant fees apply to credit card transactions. We will submit the claim to Medicare and the rebate will go into your nominated bank account. Thank you!

**CANCELLATION POLICY:**

To cancel appointments with **Dr Sanjay Sinhal at Ashford specialist Centre** please call reception on 08 8490 5690.

We require a minimum of **24 hours notice** to cancel or to reschedule appointments. Cancellations or rescheduling will only be accepted via email at [reception@sapan.health](mailto:reception@sapan.health)

Patients seeing **doctors** will incur a minimum of a \$100 fee.

Patients seeing **allied health practitioners** will be charged 100% of the scheduled fee.

**NDIS** patients are required to notify us of cancellations within 48 hours as per the NDIS guidelines or 100% of the schedule fee will be charged.

**\*Please also note, multiple cancellations without sufficient notice may result in all ongoing future appointments being cancelled\***

**Parking:**

Please arrive 15 minutes early for your appointment. Free parking is available in front of the building, with entry via Payneham Road. If these spaces are full, additional parking is available on the adjacent Marlborough Street.

**PRIVACY INFORMATION | ACKNOWLEDGMENT AND CONSENT**

To give your child and your family the best possible care and support, it is important that we have up to date personal details eg: Medicare details or bank account details and other relevant information such as relevant medical results and/or assessments and reports. We ask that you **keep us informed of any change of details**. We may use this information for our practice administrative purposes including for billing purposes, contacting Medicare, NDIS, health fund etc on your behalf. We may also need to share this information to other treating doctors and/or other health care organisations outside of our practice for the purpose of ongoing treatment, referrals and care. All information will be handled with care and in a sensitive and confidential manner.

I consent to information being shared to and from staff and practitioners at SA Paediatrics & Newborns as well as other external practices/organisations for the purpose of continuity of quality healthcare and support to your child and family. I consent to the payment of SAPAN accounts for **services held** and understand SAPAN's **cancellation policy** as outlined above.

.....  
**Print Parent Name**

.....  
**Date**

