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/Dr)*		
***Surname**		
***Given Names(s)**		
Preferred Name *(if applicable)*		
Previous Surname *(if applicable)*		
***Date of Birth**		
***Place of Birth** *(State or Country if outside of Australia)*		
***Street Address**		
***Suburb**		
***Post Code**		
***Mobile Telephone**		
Home Telephone		
Work 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:		
When did you and your partner begin trying to conceive?	**Month:**	**Year:**
Have you been investigated or treated for infertility before?		

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			