

# Consumer Information

To collect common demographic and other essential consumer information that can be shared with another agency.

## Consumer

Name: \_\_\_\_\_

Date of Birth: dd/mm/yyyy / /

Sex: \_\_\_\_\_

UR Number: \_\_\_\_\_

or affix label here

## Consumer Details

Family Name: \_\_\_\_\_

Given Names: \_\_\_\_\_

Preferred Name/s: \_\_\_\_\_

Date of Birth: dd/mm/yyyy / /

Is the date of birth estimated?  Code:

Sex: \_\_\_\_\_ Code:  Title: \_\_\_\_\_

### Home Address

\_\_\_\_\_  
Post code: \_\_\_\_\_

### Postal Address (if different from above)

\_\_\_\_\_  
Post code: \_\_\_\_\_

Contact phone number/s (tick preferred number) Can leave message?

Home: ( )  Yes  No

Work: ( )  Yes  No

Mobile:  Yes  No

Email:  Yes  No

Country of Birth: \_\_\_\_\_ Code:

Indigenous Status: \_\_\_\_\_ Code:

Need for Interpreter Services: \_\_\_\_\_ Code:

Preferred Language: \_\_\_\_\_ Code:

Communication Method: \_\_\_\_\_ Code:

## General Practitioner

GP Name: \_\_\_\_\_

Practice Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

Email: \_\_\_\_\_

## Who the Agency Can Contact if Necessary

(e.g. carer, parent, case manager, next of kin, guardian, friend, emergency contact)

### Person 1 Name:

Contact Address

\_\_\_\_\_  
Post code: \_\_\_\_\_

### Phone numbers

Home: \_\_\_\_\_

Work: \_\_\_\_\_

Mobile: \_\_\_\_\_

Relationship to Consumer: \_\_\_\_\_ Code:

Is this person the consumer's carer? Code:

Is this person the person who makes the consumer's legal decisions? Code:

### Person 2 Name:

Contact Address

\_\_\_\_\_  
Post code: \_\_\_\_\_

### Phone numbers

Home: \_\_\_\_\_

Work: \_\_\_\_\_

Mobile: \_\_\_\_\_

Relationship to Consumer: \_\_\_\_\_ Code:

Is this person the consumer's carer? Code:

Is this person the person who makes the consumer's legal decisions? Code:

Legal Orders: \_\_\_\_\_ Code:

Government Pension/Benefit Status: \_\_\_\_\_ Code:

Health Care Card Holder Status: \_\_\_\_\_ Code:

Card number: \_\_\_\_\_

Medicare Card: \_\_\_\_\_

Card number: \_\_\_\_\_

Health Insurance Status: \_\_\_\_\_

Insurer name: \_\_\_\_\_

Card number: \_\_\_\_\_

DVA Card Entitlement: \_\_\_\_\_

DVA card type: \_\_\_\_\_ Code:

DVA card number: \_\_\_\_\_

Compensables Funding Source: \_\_\_\_\_ Code:

Comments:

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