

# NCACCH Service Access Form

## Part A

DEMOGRAPHIC INFORMATION			
Medical Record Number			
NCACCH HAC Number		EXT	
Is the patient registered for the Closing the Gap Indigenous Health Incentive? (annual)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Date.....
Is this patient registered for the Closing the Gap PBS Co-payment measure? (once only)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Date.....
General Practitioner			
Date Attended			

## Part B

CLINICAL INFORMATION	ADULT HEALTH (15+ years of age)	CHILD HEALTH (0-14 years of age)
Is the patient a smoker? <b><i>N.B: This question <u>must</u> be completed</i></b>	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Result of ear examination? <b><i>N.B: This question <u>must</u> be completed</i></b>		Normal <input type="checkbox"/> Abnormal <input type="checkbox"/>
<b><i>Tick all boxes below relevant to the patient's current presentation</i></b>		
Cardiac	<input type="checkbox"/>	<input type="checkbox"/>
Dermatology	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine	<input type="checkbox"/>	<input type="checkbox"/>
ENT	<input type="checkbox"/>	<input type="checkbox"/>
Gastro-Intestinal	<input type="checkbox"/>	<input type="checkbox"/>
Immunisation	<input type="checkbox"/>	<input type="checkbox"/>
Mental Health	<input type="checkbox"/>	<input type="checkbox"/>
Musculo-Skeletal	<input type="checkbox"/>	<input type="checkbox"/>
Renal	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory	<input type="checkbox"/>	<input type="checkbox"/>
Sexual/Reproductive	<input type="checkbox"/>	<input type="checkbox"/>
Pregnancy ( <i>optional</i> )	<input type="checkbox"/>	
Other ( <i>please state</i> )		