

INTRODUCTORY REGISTRATION FORM

If question is irrelevant or information not known, write Not Applicable or NA



MS Australia -
ACT/NSW/VIC

MS Australia – ACT/NSW/VIC Privacy Statement

All personal and health information will be treated confidentially by MS Australia – ACT/NSW/VIC. No information that directly identifies you, such as your name or other personal details, will be provided to other agencies without your consent.

We are required to release certain anonymous statistical information about our service users to the Department of Human Services (DHS) in Victoria and Department of Ageing, Disability and Home Care (DADHC) in NSW. This assists in ongoing service planning and enables the continuation of government funding which will be used to plan for better service provision for people with a neurological condition.

By completing registration with MS Australia – ACT/NSW/VIC you are providing your consent to the above.

Your Details

Surname:		Title:
Given names:	Preferred name:	
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth:	
Postal address:	Postcode:	
Preferred contact phone number:	Email:	
Cultural background: If applicable: Indigenous status <input type="checkbox"/> Aboriginal <input type="checkbox"/> Torres Strait Islander	Interpreter required: <input type="checkbox"/> No <input type="checkbox"/> Yes	
Preferred Language:		
Is it acceptable for MS staff to leave messages on your preferred contact number stating they are calling from MS Australia – ACT/NSW/VIC? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Do you wish to receive regular mailouts from MS Australia – ACT/NSW/VIC? <input type="checkbox"/> All <input type="checkbox"/> Service Info only <input type="checkbox"/> None		
Do you consent to your personal information being used for MS research initiatives? <input type="checkbox"/> YES <input type="checkbox"/> NO		

Please post/fax/email this form to:

ACT
Gloria McKerrow House
117 Denison St
Deakin ACT 2600
Fax: (02) 6234 7099

MS Connect (Ph: 1800 042 138)

NSW
Studdy MS Centre
PO Box 210
Lidcombe NSW 1825
Fax: (02) 9646 0672

VIC
The Nerve Centre
Locked Bag 900
Blackburn VIC 3130
Fax: (03) 9845 2777

Email: msconnect@msaustralia.org.au Website: www.msaustralia.org.au/actnswvic

For Office Use Only:

Active registration completed on TCM: Date ____/____/____ Staff member: _____
UR#: _____ Region: _____ Municipality: _____

COMPLETE REGISTRATION is required to access program and services support
 In addition to page 1, please complete page 2 and 3 if you wish to receive services

COMPLETE REGISTRATION FORM

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AUSTRALIA
Giving life back

MS Australia -
ACT/NSW/VIC

Your Details

Home address:		Postcode:
Home phone number:	Mobile:	
<input type="checkbox"/> This is my preferred contact phone number	<input type="checkbox"/> This is my preferred contact phone number	
Work phone number:	Email:	
<input type="checkbox"/> This is my preferred contact phone number		
Country of birth:		

Living Arrangements

<input type="checkbox"/> Alone	<input type="checkbox"/> Private residence
<input type="checkbox"/> With family	<input type="checkbox"/> Residential Aged Care Facility
<input type="checkbox"/> With others	<input type="checkbox"/> Supported Residential Service (SRS)
<input type="checkbox"/> Rental : Private Public	<input type="checkbox"/> Other :

Doctors Details – if no GP or Neurologist, write NA

General Practitioner	Neurologist
Name:	Name:
Address:	Address:
Phone:	Phone:
Fax:	Fax:
Email:	Email:

Employment / Income Status

<input type="checkbox"/> Employed	<input type="checkbox"/> Not in labour force
<input type="checkbox"/> Unemployed	<input type="checkbox"/> Job seeking
<input type="checkbox"/> Pension Type:	<input type="checkbox"/> DVA card Type:
<input type="checkbox"/> Non-government benefits	

Carer Status

Do you have the support of a:	Do they live in the same household? Yes No		Relationship to you:	Age: (approx)
<input type="checkbox"/> informal carer				
<input type="checkbox"/> family member				
<input type="checkbox"/> friend				
<input type="checkbox"/> neighbour				
Do you consent to MSA directly contacting the above carer regarding Carer programs and support services? <input type="checkbox"/> Yes <input type="checkbox"/> No Contact name: _____ Contact number: _____				

Diagnosis

<input type="checkbox"/> Multiple sclerosis <input type="checkbox"/> Other neurological condition <input type="checkbox"/> Unknown	
Year of diagnosis:	Specify type of MS or other neurological condition:

Consent to Record and Release Personal and Medical Information

I give my consent for MS Australia – ACT/NSW/VIC to <i>re/lease</i> medical information from / to my referring neurologist and/or general practitioner. I understand that release of <u>any</u> personal information to another third party (including my family) will only occur with my formal consent.		
Name of client or guardian/ representative:		
Signature of client or guardian/ representative:		
Verbal consent received by staff member:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Staff name: _____
Date:		

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