Dr Jim Tsaltas
Surgical & Endoscopic Excellence
MBBS FRCOG FRANZCOG

Enclosed in this letter is some brief information about our practice and its policies for you to read through and send back to us prior to your appointment with Dr Tsaltas. Please read through this information carefully as we require you to complete a few things prior to your appointment. This Medical Practice collects information from you for the primary purpose of providing quality healthcare. We ask you to provide us with your personal details and a full medical history so that we may properly assess, diagnose, treat and be proactive in your healthcare needs.

Attached is our Patient Registration & Confidentiality Medical Information forms for you to complete prior to your appointment. Please send these back to us along with your referral letter and any relevant Medical History (including relevant results, previous treatment information etc). Please ensure we receive this at least one (1) week prior to your scheduled appointment

In the event that you are not able to attend or need to change the date of your scheduled appointment, notification needs to be received at least 48 hours prior (two business days prior) to the appointment. Please note that if you do not confirm your appointment with us, we will assume you will not be coming and this appointment will be cancelled.

**CONSULTING ROOMS**

Dr Tsaltas has rooms in East Melbourne, Mount Waverley & Mornington. If you are unsure of where your appointment has been made for you, please contact the rooms as to avoid arriving at the wrong rooms as there will be a further waiting time to re schedule your appointment.
The East Melbourne Rooms are located at the Epworth Freemasons Medical Centre at Suite 119, 320 Victoria Parade, East Melbourne 3002. Parking is located in the surrounding streets as well as underneath the building.
The Mount Waverley Rooms are located at 81 Blackburn Road, Mount Waverley 3149. This is on the corner of Kendall Street and Blackburn Road. There is street parking in Kendall Street and limited parking on site with access from Kendall Street.
The Mornington Rooms are located at Suite 8, The Bays Hospital on the corner of Vale and Main Street in Mornington. There is ample parking on site.

**CONSULTATION FEES**

Payment for accounts is on the day of consultation. We accept VISA/Master Card/EFT, cheque and cash. Other fees may be applicable to your consultation depending on what procedures are performed on that day, or if your appointment is for a second opinion. These are available on request, please phone the rooms if you would like further information regarding this. Please note our fees are subject to change without notice. Please note the fees below are based on a standard consultation, if you have an extended consultation the fees will increase depending on the length of your consultation.

| | | | |
|---|---|---|---|
| **Item 104** - Initial Consultation | $340.00 | Medicare Rebate | $72.75 |
| **Item 105** - Review Consultation | $180.00 | Medicare Rebate | $36.55 |
| **Item 104** - Initial Consultation (2nd opinion) | $400.00 | Medicare Rebate | $77.00 |

Please note: We are currently unable to take payment at the Mornington Rooms, you will need to contact Dr Tsaltas' main rooms in East Melbourne the following business day to pay your account to avoid a late fee.**

**REFERRAL**

According to the Health Insurance Commission it is the patient's responsibility to get a referral and ensure that it is kept up to date. Referrals from a specialist are only valid for three months.
Referrals from a GP are valid for 12 months. A new referral is required every time you present with a new condition. Please contact the rooms if you have any personal questions about your referral and its validity.

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**CANCELLATION LIST**

We run an active cancellation list at our practice. If you would like to be placed on this list please make sure you let us know. We will contact you on your preferred contact number if/when any cancellations occur. If your medical conditions worsen please get your GP to send through your referral and any relevant investigation results for you to be elevated on our cancellation list. Please note cancellations do occur but we cannot guarantee all patients a cancellation appointment offer. We will only contact patients with two offers of a cancellation appointment. If we are not able to get hold of you or you are unable to accept these offers you will be taken off the cancellation list. If you have any questions regarding this please do not hesitate to contact our rooms for further clarification.

**CONSULTATION**

We reserve half an hour for your initial consultation to provide sufficient time to determine your requirements and to answer any questions you may have regarding your treatment. If you take longer than your allocated appointment time you will be charged at the extended consultation rate. Please make sure that you arrive ten (10) minutes prior to your appointment to confirm your details etc. If you are late arriving to your appointment, we may be forced to reschedule your appointment. Certain conditions/procedures may also require pathology samples to be taken for analysis and this will incur a separate account generated by the pathology company.

**SURGERY**

If it is recommended that surgery is required, we will provide you with detailed written information that includes procedure details, procedure consent forms, cost estimate for the anticipated procedure and any additional information approximately two weeks prior to your surgery date. If you require this information earlier than two weeks for any reason, please alert the reception staff and we will try to complete your paperwork as soon as we possibly can. Please note Dr Tsaltas charges fees recommended by the AMA (Australian Medical Association) for all of his surgical procedures and does not participate in gapcover or ezyclaim. There will be an out of pocket cost for your surgery.

If you have any queries in the meantime regarding this letter, its contents or your future treatment with us please do not hesitate to contact our office on +613 9416 1172 or via email at drtsaltas.reception@mivf.com.au.

Our office hours are Monday to Friday 9.00am to 5.00pm.

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**PATIENT REGISTRATION FORM**

(Mrs/Ms/Miss) Surname: _____

Given Name: _____

Preferred Name: _____

Date of Birth: _____/_____/_____ Blood Group: _____

Address: _____
_____ Post Code_____

Phone: (Home) _____ (Work) _____ (Mobile) _____

E-mail Address: _____

Medicare No: _____ Your Ref No: _____

Medicare Expiry: _____ / _____

Do you have Health Cover other than Medicare: YES ☐/ NO ☐

Private Health Fund: _____

Membership Number: _____

Referring doctor:_____

Name & Address of General Practitioner (if not referring Doctor): _____
_____

Occupation: _____

Next of Kin: _____ Phone (Home) _____

Relationship: _____(Mobile) _____

Emergency Contact (other than next of kin - 2nd Contact Person)

Name: _____Phone: _____

How did you hear about us? _____

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**PLEASE PROVIDE YOUR HUSBAND / PARTNER'S DETAILS**

Partners Name: _____ Date of Birth: _____/_____/_____

Phone: (Home) _____ (Work) _____ (Mobile) _____

Medicare No: _____ Your Ref No: _____

Medicare Expiry: _____ / _____

Occupation: _____

PRIVACY STATEMENT:
This medical practice collects information from you for the primary purpose of providing quality health-care. We ask you to provide us with your personal details and a full medical history so that we may properly assess, diagnose, treat and be proactive in your healthcare needs. We may use the information you provide for administrative purposes in running our medical practice including billing and compliance with Medicare and Health Insurance Commission requirements. Information may be sent / received to other practitioners involved in your care. Confidentiality will always be maintained if any information related to your care is used in research, quality assurance or educational purposes.

PAYMENT PROCEDURES:
All accounts are to be paid on the day.

I consent to the handling of my information by this practice for the purpose set out above.
I understand my obligation with regard to payment of my account and any additional charges.

**Patient/Guardian signature: _____ Date_____

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**CONFIDENTIAL INFORMATION** (Our Ref:10917)

NOTE: Please take the time to fill out this questionnaire as your information will ensure I have the best possible understanding of your circumstances prior to your consultation. Take your time and read all the questions carefully. Please send this form back completed along with your completed patient registration form. Please note you need to complete the female component of both pages regardless of what you are being seen for (Gynaecological Problems / Infertility),

Female: Surname: _____Given Name: _____

DOB:_____/_____/_____

Male: Surname: _____Given Name: _____

DOB:_____/_____/_____

SPECIFIC QUESTIONS FOR THE FEMALE PARTNER (IVF & GYNAE PATIENTS)

How old were you when you had your first period? _____

On average, how long is your cycle? (From the 1st day of your period until the 1st day of your next period) _____to _____days.

On average, how many days does your period last? (From the 1st day until the last day of your period) _____days.

Is your period painful? YES ☐/ NO ☐

Do you feel that the amount of blood loss is abnormal? YES ☐/ NO ☐

Do you have a lot of symptoms prior to your period? YES ☐/ NO ☐

Is there vaginal blood loss between your periods? YES ☐/ NO ☐

Is intercourse painful? YES ☐/ NO ☐

Have you been diagnosed with Endometriosis? YES ☐/ NO ☐

Do you or your GP think you have Endometriosis? YES ☐/ NO ☐

Have you ever been Pregnant? YES ☐/ NO ☐

If YES, when was your last Pregnancy? _____

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If YES, please specify how many pregnancies you have had below:

| | Current Partner | Previous Partner(s) |
|---|---|---|
| Miscarriages | _____ | _____ |
| Terminations of Pregnancy | _____ | _____ |
| Ectopic Pregnancies (e.g. in the tube) | _____ | _____ |
| Live Births | _____ | _____ |

If you are trying to get pregnant, how many months have you been trying to get Pregnant? _____

Have you ever received any fertility treatment? YES ☐/ NO ☐

If YES, please specify: _____

Have you ever used / received contraception? YES ☐/ NO ☐

If YES, please specify: _____

Life Style: Weight (kg): _____ Height (cm): _____

Have you lost or gained a lot of weight recently? YES ☐/ NO ☐

Do you smoke? YES ☐/ NO ☐ How many cigarettes per day? _____

Do you drink alcohol? Regularly ☐/ Rarely ☐/ Never ☐

When was your last Pap Smear? _____

Was it normal? YES ☐/ NO ☐

Have you ever had an operation: YES ☐/ NO ☐

If YES, have you ever had a Caesarean Section: YES ☐/ NO ☐ Year: _____

Operation on the cervix: YES ☐/ NO ☐ Year: _____

Laparoscopy (telescope through the belly-button): YES ☐/ NO ☐ Year: _____

Gynaecological Operation via abdominal incision: YES ☐/ NO ☐ Year: _____

Operation on the Bowel (e.g. appendectomy): YES ☐/ NO ☐ Year: _____

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Any other surgery: YES ☐/ NO ☐ Year: _____

Have you ever been treated for one of the following illnesses?

Diabetes: YES ☐/ NO ☐

Thyroid Disease: YES ☐/ NO ☐

Tuberculosis: YES ☐/ NO ☐

Have you ever been hospitalised for an illness? YES ☐/ NO ☐

If YES, please specify: _____

Are you currently under any form of treatment? YES ☐/ NO ☐

If YES, please specify: _____

Do you have any diseases that run in the family? YES ☐/ NO ☐

If YES, please specify: _____

Are you on any regular medication? YES ☐/ NO ☐

Which medication?: _____

Do you have any allergies (medication, food)? _____

Do you know of any inherited family illnesses? _____

Are you under any other specialist practitioners? _____

Are you on any alternative medicines? _____

Personal Remarks: _____

_____

_____

_____

_____

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SPECIFIC QUESTIONS FOR THE MALE PARTNER (IF PRESENTING PROBLEM IS INFERTILITY)
(Our Ref:10917)

Life Style: Weight (kg): _____ Height (cm): _____

Have you lost or gained a lot of weight recently? YES ☐/ NO ☐

Do you smoke? YES ☐/ NO ☐ How many cigarettes per day? _____

Do you drink alcohol? Regularly ☐/ Rarely ☐ / Never☐

Do you come into harmful substances in your workplace? YES ☐/ NO ☐

Have you ever had one of the following illnesses?

Diabetes: YES ☐/ NO ☐

Thyroid Disease: YES ☐/ NO ☐

Liver or Kidney Disease: YES ☐/ NO ☐

Chronic Lung Disease: YES ☐/ NO ☐

Do you know of people in your family who have inherited condition? YES ☐/ NO ☐

If YES , what? _____

Have you ever had an operation? YES ☐/ NO ☐

If YES, have you ever had an:
Operation on one / both testicles: YES ☐/ NO ☐ Year: _____

Vasectomy: YES ☐/ NO ☐ Year: _____

Operation on your bladder: YES ☐/ NO ☐ Year: _____

Prostate Operation: YES ☐/ NO ☐ Year: _____

Operation on your penis: YES ☐/ NO ☐ Year: _____

Inguinal hernia repair: YES ☐/ NO ☐ Year: _____

Operation on your spinal cord: YES ☐/ NO ☐ Year: _____

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Have you ever had mumps? YES ☐/ NO ☐ If YES, at what age? _____

Have you ever experienced severe pain in one / both testicles? YES ☐/ NO ☐

Have you ever been treated for undescended testicle? YES ☐/ NO ☐

Have you ever been treated for a urinary infection? YES ☐/ NO ☐

Have you ever had problems with erection / ejaculation? YES ☐/ NO ☐

If you have had other partners, were any of them ever pregnant? YES ☐/ NO ☐

Are you on any regular medication? YES ☐/ NO ☐

Which medication?:_____

Do you have any allergies (medication, food)? _____

Personal Remarks: _____

_____

_____

_____

_____

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