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| **Baby Information** | |
| Baby's First Name: |  |
| Baby's Last Name: |  |
| Date of Birth: |  |
| Medicare Card Number: (if available) |  |
| Healthcare Card Number: (if available) |  |
| Ethnicity (country of origin): |  |
| **Parent Information** | |
| Mother's Name: |  |
| Mother's Date of Birth: |  |
| Contact Phone Number: |  |
| Mother’s Medicare Card: |  |
| Healthcare Card Number: (if available) |  |
| Father's Name: |  |
| Father's Date of Birth: |  |
| Contact Phone Number: |  |
| Father's Medicare Care Card Number: |  |
| Healthcare Card Number: (if available) |  |
| **Contact Information** | |
| Residential Address: |  |
| Suburb: |  |
| Post Code: |  |
| Home Phone Number: |  |
| Email Address: |  |
| Family Doctor Name: |  |
| Family Doctor's Phone Number: |  |
| Family Doctor's Address: |  |
| How did you hear about us? |  |

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| **Medical History** | |
| Has your son had any medical or bleeding problems, or blood loss, since birth? YES / NO  Does your family have any history of bleeding problems? YES / NO  Do you have any reason to believe that your son has low blood or low haemoglobin? YES / NO  If Yes, Please explain:  Allergies Yes /No if yes please explain  Panadol time given to patient: | |
| Were there any significant problems for baby or mother during delivery? YES / NO  If Yes, please explain: | |
| *Please list any medications your son is taking:*  YES / NO | |
| Medication Name / Dosage: |  |
| Medication Name / Dosage: |  |

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| **Circumcision Consent: PLEASE READ CAREFULLY AND TICK THE BOXES** | |
| We have carefully considered the risks and benefits of this procedure and have discussed them with our family physician or other healthcare professional prior to seeing Dr. Sharier.  We understand that, according to the Royal Australian College of Physician and Paediatrics do not support routine Infant / children Male Circumcision.  We understand that we are making a consent by proxy for our infant for a non-therapeutic procedure. By signing this form, we have given our consent to this procedure as parents of this child.  We agree to have our son circumcised by Dr Mohammad Sharier. By signing this form, we have given our consent to this procedure as parents of this child.  We agree to have our son circumcised by Dr Mohammad Sharier. By signing this consent form we are acknowledging that the complications and risks of this procedure have been explained to us.  We understand that complications after circumcision can occur, although the frequency varies with the skill and experience of the doctor, and are infrequent in Pollock Technique.  Complications include:   * Significant post-op bleeding (1 in 400) * Phimosis or narrowing of the shaft-skin opening over the head of the penis (1 in 500) * Buried or trapped penis in the abdomen (1 in 800) * Infection requiring antibiotics (1 in 1000) * Meatal stenosis or narrowing of the urethra (1 in 1000) * Sub-optimal cosmetic outcome (1 in 500) * Trauma to the head of the penis (never in this practice) * More serious complications including death (never in this practice)   We confirm that we have not given any anti-inflammatory medications to our son within the last 7 days. Examples: ADVIL, IBUPROFEN, ASPIRIN, etc. |  |

Mother Name Print \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sign\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_

Father Name Print \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sign \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_