GP partners AUSTRALIA
supporting GPs to care for the community

Government of South Australia
SA Health

GP Palliative Shared Care Program – Registration Form

PERSONAL DETAILS (as shown on AHPRA Registration)

Title: _____ Given Name/s: _____ Surname: _____

Preferred Name: _____ Gender: ☐ Male ☐ Female

Phone: _____ Email: _____

Languages spoken (other than English): _____

☐ General Practitioner ☐ Registrar (Completion date: _____)

AHPRA Registration Number: _____ RACGP QI&CPD Number: _____

PRACTICE DETAILS

1. Practice Name: _____

   Address: _____

   Phone: _____ Fax: _____

2. Practice Name: _____

   Address: _____

   Phone: _____ Fax: _____

PARTICIPATION

- As a participant in the GP Palliative Shared Care Program:
  - ☐ I would consider caring for new patients with a progressive, life limiting illness

    OR
  - ☐ I am unable to accept new patients with a progressive, life limiting illness at this time
- I consent to my name and practice details being included on the GP Palliative Shared Care Database, accessible to Specialist Palliative Care Services, GP Advisors and GP partners Australia.

Signature: _____ Date: _____

Please return the completed form to:

GP partners Australia
Post: PO Box 7293, Hutt Street SA 5000
Fax: (08) 8227 2220
Email: gbutler@gppaustralia.org.au
GP Palliative Shared Care Information Line: 1300 303 409