Government of South Australia
Women's and Children's Health Network

GP Partners Australia

GP ADHD Shared Care Program – Registration Form

PERSONAL DETAILS (as shown on AHPRA Registration)

Title: ________ Given Name/s: ____________________________________ Surname: ____________________________________

Preferred Name: ____ Share your Pronouns: ……………………………………………

Phone: _________________________________ Email: ____

Languages spoken (other than English): ____

☐ General Practitioner ☐ Registrar (Completion date: ___________________)

AHPRA Registration Number: ____________________________ RACGP CPD Number/ACRRM Number: __________________

PRACTICE DETAILS

1. Practice Name: ____Practice Nurse : __________________________________

   Address: ____

   Phone: _____________________________ Fax: ___________________________

2. Practice Name: ____Practice Nurse: ___________________________________

   Address: ____

   Phone: _____________________________ Fax: ___________________________

PARTICIPATION

- As a participant in the GP ADHD Shared Care Program:
  - ☐ I would consider taking both my existing patients and new patients in the GP ADHD Program

    OR
  - ☐ I would consider taking only my existing patients and am unable to take new patients at this time

    OR
  - ☐ I am unable to accept patients at this time, but would like to register to receive information
- I consent to my name and practice details being included on the GP ADHD Shared Care Database, accessible to Child & Adolescent Mental Health Services, GP Advisor/s, and GP Partners Australia.

Signature: ____ Date: ______________________

Please return the completed form to:

GP Partners Australia
Post: PO Box 7293, Hutt Street SA 5000
Phone: (08) 8112 1100 | **Fax**: (08) 8227 2220 | **Email**: lmarch@gppaustralia.org.au