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| **Personal Information**  |
| **Patient Name** | [Author] |
| **Hospital MRN** |  | **AUID** |  |
| **DOB** |  | **Height** |  | **Weight** |  |
| **Address** |  |
| **PH** |  | **E** |  |
| **Parent/Carer** |  | **PH** |  | **E** |  |
| **Next of Kin** |  | **PH** |  | **E**  |  |
| **Medicare** |  | **Position**  |  | **EXP**  |  |
| **Health Care Card** |  | **EXP** |  |
| **Pensioner Concession Card** |  | **EXP** |  |
| **DVA Health Card** |  | **EXP** |  |

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| **Private Insurance** |
| **Company** |  | **Number:** |  |
| **Cover type** |  |

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| **Allergies** |
| *[Write drug allergies here]* |

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| **Medical Information** |
| **I have a Primary Immunodeficiency called:** *[Insert PID]*[**ORPHA NO:**](https://www.orpha.net/consor/cgi-bin/Disease_Search.php?lng=EN&data_id=10964&Disease_Disease_Search_diseaseGroup=Specific-anti-polysaccharide-antibody-deficiency&Disease_Disease_Search_diseaseType=Pat&Disease(s)/group%20of%20diseases=Immunodeficiency-due-to-selective-anti-polysaccharide-antibody-deficiency&title=Immunodeficiency%20due%20to%20selective%20anti-polysaccharide%20antibody%20deficiency&search=Disease_Search_Simple)  *List the ORPHA Number and add a link.***About *[Insert PID]:**** *Write something about your PID here and add a link.*
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| **Patient Name** | [Author] |

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| **Medical Information (Continued)** |
| ***[Insert PID]* Crucial care points:*** Lack of fever may not be indicative of the severity of illness.
* At risk of severe infections by atypical organisms.
* More at risk to COVID-19 and need access to monoclonal antibodies.
* Isolation precautions due to infection susceptibility.
* Contact GP/Primary Care Specialist 1 if needed for care requirements.
* **GP:** *[GP name],**[GP Number]*
* **Primary Care Specialist 1:** *[Primary Care Specialist name],* *[Primary Care Specialist Number]*
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| **Medical Team** |
| **TEAM** | **Specialty** | **Treating Healthcare Professional** | **Address** | **PH** | **HOSP SWITCH** | **FAX** | **Email** |
| LOCAL GP | GP | *[GP name]* |  | *[GP Number]* |  |  |  |
| **CONDITIONS TREATED** (list) |  |
| PRIMARY CARE SPECIALIST 1 |  | *[Primary Care Specialist name]* |  | *[Primary Care Specialist Number]* |  |  |  |
| **CONDITIONS TREATED** (list) |  |
| SPECIALIST 2 |  |  |  |  |  |  |  |
| **CONDITIONS TREATED** (list) |  |
| SPECIALIST 3 |  |  |  |  |  |  |  |
| **CONDITIONS TREATED** (list) |  |
| SPECIALIST 4 |  |  |  |  |  |  |  |
| **CONDITIONS TREATED** (list) |  |
| SPECIALIST 5 |  |  |  |  |  |  |  |
| **CONDITIONS TREATED** (list) |  |
| SPECIALIST 6 |  |  |  |  |  |  |  |
| **CONDITIONS TREATED** (list) |  |
| SPECIALIST 7 |  |  |  |  |  |  |  |
| **CONDITIONS TREATED** (list) |  |
| SPECIALIST 8 |  |  |  |  |  |  |  |
| **CONDITIONS TREATED** (list) |  |
| SPECIALIST 9 |  |  |  |  |  |  |  |
| **CONDITIONS TREATED** (list) |  |
| SPECIALIST 10 |  |  |  |  |  |  |  |
| **CONDITIONS TREATED** (list) |  |

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| **Patient Name** | [Author] |

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| **Diagnoses**  |
| **Primary Diagnosis** | **Year** |
| CVID | 2023 |
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| **Secondary Diagnosis** | **Year** |
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| **Patient Name** | [Author] |

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| **Medications** |
| **Medication** | **Dose** | **How often** | **Condition** |
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| **Treatment Plan for:** *If you have a treatment plan approved by your Hospital/Specialist/GP for a certain condition, list it here* |
| **Medication** | **Dose** | **How often** |
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| **Treatment Plan for:** *If you have a treatment plan approved by your Hospital/Specialist/GP for a certain condition, list it here* |
| **Medication** |  **Dose** | **How often**  |
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| **Patient Name** | [Author] |

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| **Immunisations** | **Date** |
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| **Operations** | **Date** |
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| **Family History** |  |
| **Family member** | **Age** | **Illnesses/Diseases history** |
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