Your Ref: **COR 2014 005936**

RUMBALARA
ABN 84530647942

10 February 2020

Coroners Court of Victoria
65 Kavanagh Street
SOUTHBANK VIC 3006

Dear Sir/Madam

Investigation into the death of Travis L Fernandez

I respond to the letter (and enclosures) to Rumbalara dated 21 January 2020, from Ms Olivia Collard, Coroners Registrar (hereafter the "**Letter**") as follows:

After considering the Letter, Rumbalara wishes to extend its deepest sympathy to the family and friends of Mr Fernandez, following his tragic passing.

With regard to Recommendation 4 of the Coronial Report from Paresa Antoniadis Spanos (hereafter the "**Coroner(s)**") dated 14 January 2020 namely:
"That Rumbalara Aboriginal Co-operative Limited consider revising its Medical History Questionnaire to include a field, preferably on the first page of the document, to ensure that information relating to 'previous/recent dental surgery' (or similar) is captured.

Rumbalara advises that the **Coroners Recommendation will be implemented**. This decision to modify the Rumbalara Medical History Questionnaire was taken following receipt of the Coroner's recommendation, and a copy of the new Medical History Questionnaire, is attached to this letter.

Yours sincerely
RUMBALARA ABORIGINAL CO-OPERATIVE LTD

Felicia Dean
Chief Executive Officer

Corporate Services
31 Wyndham Street Shepparton
Ph: 03 5820 0000 Fax: 03 5820 0064

Community Services
20 Rumbalara Road, Mooroopna Ph: 03 5820 0000 **Family Fax:** 03 5831 2370
Justice Fax: 03 5820 0009 **Housing Fax:** 03 5825 3680

Positive Ageing & Disability Services
95 Ford Road Shepparton **(Elders Facility)** Ph: 03 5820 6200 Fax: 03 5822 4893
(Aged Care) Ph: 03 5822 2866 Fax: 03 5831 3549

Health & Wellbeing
20 Rumbalara Road, Mooroopna Medical Appointments: Ph: 03 5820 0035
Medical Fax: 03 5825 3500 **Dental** Fax: 03 5820 0060

RUMBALARA
ABORIGINAL CO-OPERATIVE LTD.

DENTAL CLINIC

FILE NO:.....

SURNAME:.....

GIVEN NAMES:.....

DATE OF BIRTH:.....

IN CONFIDENCE – GENERAL HEALTH QUESTIONNAIRE

Please answer all of the following questions.

If you are taking multiple medications, please obtain a list from your doctor or specialist to assist in future dental treatment. This includes over the counter medications.

If you are unsure about anything, please discuss with dental staff

QUESTIONS	Please circle your answer
Have you ever stayed in Hospital, had an operation or a general anaesthetic? If YES, please specify details and approximate dates:	YES/NO
Have you ever had any serious problems after dental treatment	YES/NO
Do you have diabetes? If YES, what type?	YES/NO
Have you ever had kidney problems? If YES, please specify	YES/NO
Do you smoke? If YES, approximately how many a day?	YES/NO
Have you ever had any type of heart disease, including high blood pressure, heart murmur or rheumatic fever or do you have a pacemaker? If YES, please specify	YES/NO
Do you bleed excessively when you cut yourself or have any bleeding/bruising problems? If YES, please specify:	YES/NO
Have you had any recent dental surgery? If YES, please specify:	YES/NO
Have you ever had a stroke, suffer from fits or epilepsy? If YES, please specify:	YES/NO
Are you suffering from memory loss or have you been diagnosed with Dementia/Alzheimer's If YES, please specify:	YES/NO
Have you ever had tuberculosis, asthma or any other breathing problems? If YES, please specify:	YES/NO

Do you suffer from any liver problems? If YES, please specify:	YES/NO
Do you have any joint problems, arthritis or a history of joint replacement surgery? If YES, please specify:	YES/NO
Do you have any behavioural or psychological issues? If YES, please specify:	YES/NO
Do you have a pressure/bed sore that is currently being treated OR are you at risk of developing them? If YES – clinician to complete Pressure Injuries Risk Assessment	YES/NO
Have you had a fall in the last 28 days? If YES – clinician to complete Falls Risk Assessment	YES/NO
Do you have any other medical or disability problems that are not listed? (For example: physical, sensory or intellectual disabilities) If YES, please specify:	YES/NO
Do you have any allergies or had a reaction to medicines or latex? If YES, please specify:	YES/NO
Have you taken any medication for cancer (including receiving radiation therapy or chemotherapy), osteoporosis or any other bone or calcium problems in the last 10 years?	YES/NO
Are you taking any anticoagulants or taking any medicines to thin your blood?	YES/NO
Are you currently taking any medication, or have you taken any in the last 3 months? If YES, please specify below.	YES/NO
FOR WOMEN ONLY: Are you pregnant or breast feeding?	YES/NO

MEDICATION	DOSE	FREQUENCY	MEDICATION	DOSE	FREQUENCY

NOTES:

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Who would you like us to contact in an emergency?

Name:..... Phone:.....

Patients medical doctor (GP): Name:.....

Address:.....

Phone:.....

In order to provide you with appropriate care, Rumbalara Dental Clinic may also wish to access your medical records. Please complete the following:

I..... give Rumbalara Dental Clinic permission to access my medical records/or contact my doctor in order to request a summary on my/my child's medical history and associated medications.

Patient/Parent/Guardian

Signature:.....

Date:.....

CONSENT FOR TREATMENT BY UNIVERSITY STUDENTS

I ..... (Patient name) acknowledge that dental and oral health students will be providing dental treatment and that all procedures will be supervised by a qualified dentist/therapist employed by Rumbalara Aboriginal Co-operative.

I also understand that while I am being treated by students, there will be no co-payment fees for health care cardholders for services provided. However, if at any time my treatment needs are to be transferred to a qualified dental operator, fees will apply if applicable to the service provided.

Signed..... Patient/Parent/Guardian

Date.....

OFFICE USE ONLY: (EVERY 12 MONTHS)

General Health Questionnaire reviewed – Date: _____/_____/_____

Clinician Name:..... Clinician Signature:.....

General Health Questionnaire reviewed – Date: _____/_____/_____

Clinician Name:..... Clinician Signature:.....

General Health Questionnaire reviewed – Date: _____/_____/_____

Clinician Name:..... Clinician Signature:.....