Patient Consent

The *Gladstone GP Superclinic* requires your consent to collect personal information about you.

Please read this consent form carefully, tick the applicable boxes and sign where indicated below.

This Medical Practice collects such information for the primary purpose of providing quality health care. We require you to provide us with your personal details and a full medical history to allow us to properly assess, diagnose, treat and advise on all your health care needs. Please place a tick in the following boxes if you give consent for this information to be used by the Practice in the following ways:

- I give my permission for my personal health information to be used for administrative purposes to assist in the running of (*Gladstone GP Superclinic*), including disclosure to others involved in my healthcare, such as treating doctors and specialists within and outside this Medical Practice. This may occur through referral to other Doctors, or for medical tests and in the reports or results returned to my doctor following referrals.

- I give my consent for disclosure for research and quality assurance activities to improve individual, community health care and Practice management. This may occur when the Practice incorporates patient health records into de-identifiable patient information to transfer to a third party, normally used for quality improvement projects. De-identifiable patient information cannot be traced back to the individual.

- I give my consent for my personal health records to be used for identifiable patient health information. This may occur when the Practice participates in research activities on behalf of a university as part of professional development activities to be collected. Identifiable patient information can possibly be traced back to the individual.

- I give my consent to the presence of a third party to be present during my consultation. This may include a Practice Nurse or medical student.

☐ I give my consent to be part of the Practice's National, State and Territory recall and reminder systems, including correspondence and notifications via electronic communications.

I understand by ticking the relevant boxes above that the Practice is authorised on my behalf to use my relevant personal health information and I am free to withdraw my consent at any one time by verbal or written notification.

NON-ENGLISH SPEAKING PATIENTS ONLY

I _________________ translated the above information to___________________ and they have signed below.

(NAME) *(NAME OF PATIENT)*

Understanding this Practice is authorised on their behalf to use their relevant personal information and they are free to withdraw their consent at any one time by verbal or written notification.

Print name of Patient: ______________________________

Signature of Patient: _______________________________

Print name and signature of Parent /Guardian (if under 18): ____

Date: ____ /____ /_______

STAFF USE ONLY

ENTERED BY:**__________________________** ***DATE:*** **___/___/_____** ***CHART NUMBER:*** **_________________**

PERSONAL INFORMATION					
Title:			Surname:		
First Name:			Known as:		
D.O.B:			Birth Sex: Male / Female		
Gender Identity:					
Ethnicity: Aboriginal or Torres Strait Islander: Yes / No / Both Other:					
Address:					
Postal (If different from above):					
Phone (H):			Phone(W):		
Phone (M):			☐ Consent to SMS Reminders (Please tick)		
Preferred Contact Method: *(Please circle)*					
Mobile #	Work #	Home #	SMS	Email	Letter
Consent to e-prescriptions: Yes / No : Sent via *(Please circle)* Mobile / Email / Paper					
Email:					
Medicare #:		Ref # next to your name:		Expiry:	
Concession #:			Expiry:		
Pensioner Card Type *(Please Circle)*					
Pensioners Concession Card		Health Care Card		Commonwealth Seniors Health Card	
Private Health Insurance:					
Religion:					
Occupation:					
Marital status *(Please circle)*					
Single	Married	Widowed	Divorced	Defacto	Separated
NEXT OF KIN					
Name:					
Phone:					
Relationship *(Please circle)*					
Spouse /Partner	Parent	Child	Child-in-Law	Other Relative	Friend / Neighbour
EMERGENCY CONTACT					
☐ **Same as NEXT OF KIN**					
Name:					
Phone:					
Relationship *(Please circle)*					
Spouse / Partner	Parent	Child	Child-in-Law	Other Relative	Friend / Neighbour

Please be aware we are a Private Billing Surgery and Non-Attendance fees may apply for non attendance or late cancellations