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 the Practice (*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 a third party being 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 checking the relevant boxes above that the Practice is authorised on my behalf to use my relevant personal health information and that I am free to withdraw my consent at any time by way of verbal or written notification to the Practice.

Patient Name (Please print): _____

Patient Signature: _____

Patient Parent/Guardian (If under 16yrs of age): _____

Signature of Parent /Guardian (If under 16yrs of age): _____

Date: ____ /____ /_____

NON-ENGLISH SPEAKING PATIENTS ONLY - to be completed by person translating

I (print name) _____ have translated the information contained in this

document to (Patient Name) _____

They have stated that they understand the information and have signed their consent above.

Name:_____ Signature: _____ Date: _____

STAFF USE ONLY

ENTERED BY: _____ **DATE:** ____/____/_____ **CHART NUMBER:** _____

***Please be aware we are a Private Billing Practice and fees may apply for non-attendance or late cancellation of appointments**

PERSONAL INFORMATION					
D.O.B: / /	**Title:**	**Surname:**			
First Name:		**Middle name:**			
Preferred Name:		**Birth Sex:**	☐ Male	☐Female	
Gender Identity:	☐Female	☐ Male	☐Non-binary	☐Gender Diverse	
	☐Transgender		☐Different Identity	☐Prefer not to respond	
Aboriginal or Torres Strait Islander:	☐Yes	☐No	☐Both		
Country of Birth:		**Nationality:**			
Occupation:		**Religion:**			
Address:					
Postal Address (If different from above):					
Phone (H):		**Phone(W):**			
Phone (M):		☐ **Consent to SMS Reminders (Please tick)**			
Preferred Contact Method (Please tick applicable):					
☐Mobile Ph	☐Work Ph	☐Home Ph	☐SMS	☐Email	☐Letter
Consent to E-Scripts (electronical prescriptions): ☐Yes ☐No (Will collect paper scripts)					
Email:					
Medicare #:		**Ref # next to your name:**	**Expiry:**		
Concession #:		**Expiry:**			
Pensioner Card Type *(Please tick)*					
☐Pensioners Concession Card	☐Health Care Card	☐Commonwealth Seniors Health Card			
Private Health Insurance:					
Marital status *(Please tick)*					
☐Single	☐Defacto	☐Married	☐Separated	☐Divorced	☐Widowed

EMERGENCY CONTACT				
Name:			**Phone:**	
Relationship *(Please tick)*				
☐Spouse	☐Parent	☐Child	☐Friend	☐Other:

NEXT OF KIN				
☐**Same as EMERGENCY CONTACT**				
Name:			**Phone:**	
Relationship *(Please tick)*				
☐Spouse	☐Parent	☐Child	☐Friend	☐Other: