SPRINGWOOD DAY SURGERY

PATIENT DECLARATION AND CONSENT

Record No: ....

Surname: ....

Given Names: ....

DOB: .... Sex: ....

AFFIX PATIENT IDENTIFICATION LABEL HERE

- THE FOLLOWING INFORMATION IS REQUIRED TO ENSURE YOU RECEIVE THE BEST POSSIBLE CARE PROVIDED BY **SPRINGWOOD DAY SURGERY**
- ALL CONSENTS ON THIS FORM ARE VALID UNTIL YOU CHOOSE TO REVOKE OR CHANGE THEM

SECTION 1 - COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION

I agree and acknowledge that Springwood Day Surgery or my doctor may be required by law to disclose details of my health records. I authorise and consent to Springwood Day Surgery or my doctor providing details of my health records to my health benefits organisation, authorised agent or other body as required by law. Springwood Day Surgery may share relevant health information now or in the future, with the public sector health system, GPs, specialists and other third parties where it is reasonably necessary for the provision of healthcare to me. Springwood Day Surgery will also be able to collect and share personal information where it is required or authorised by law. I acknowledge that my clinical information may be utilised from time to time for the purpose of improving the quality of our services.

☐ YES:

SECTION 2 - RIGHTS AND RESPONSIBILITIES

I have received a copy, read and understood the Springwood Day Surgery Patient Charter and understand that at any time I may discuss the Charter with the Patient Representative

☐ YES:

SECTION 3 - EMAIL COMMUNICATION

Although I have been advised that email is not a recommended means for sending health information, as it is not considered sufficiently secure, I authorise and direct Springwood Day Surgery to communicate with me via email.

☐ YES:
☐ NO:

EMAIL ADDRESS:

I authorise and direct Springwood Day Surgery to share by email with any organisation or person such information that it considers reasonably necessary for the provision of a healthcare service, where Springwood Day Surgery is unable to send the information via secure means.

☐ YES:
☐ NO:

SECTION 4 - PATIENT FEEDBACK

Patient feedback is vital to improving Springwood Day Surgery services. I understand the value of my feedback about my experience as a patient and I consent to being invited to participate in patient experience surveys.

☐ YES:
☐ NO:

SECTION 5 - GENERAL

I understand that a sample of my blood will need to be tested if there is an injury to me, my doctor or a hospital staff member during my visit. **(Note: If you have any queries in relation to this, please advise our staff who will arrange for an appropriately trained health care provider to discuss your query prior to signing this section).**

☐ YES:

I consent to **Marketing** contacting me in relation to marketing and media activities.

☐ YES:
☐ NO:

I consent to researchers contacting me to seek my approval to access my health information for **research** projects.

☐ YES:

PLEASE ENSURE YOU COMPLETE PAGE 2 OF THE PATIENT DECLARATION AND CONSENT

SPRINGWOOD DAY SURGERY

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SECTION 6 - TELEHEALTH

Under certain circumstances, Springwood Day Surgery may offer me the opportunity for a consultation to be provided via video call instead of in person with a clinician. Should this occur, I consent to participate in a video call clinical consultation and I:

☐ YES:
☐ NO:

- Understand that although Springwood Day Surgery has taken all precautions to ensure the privacy and security of the selected video call software, it cannot absolutely guarantee its security and privacy. With any online presence, it may be possible for unauthorised users to gain access to data transmitted through the video call clinical consultation.
- Agree to respect the privacy of Springwood Day Surgery staff and will refrain from recording and disseminating any recordings or images of the video call.
- Understand that health information arising from the video call consultation, as with a face to face consultation, will be stored in my health record in accordance with our policy.

SECTION 7 - MY HEALTH RECORD

Springwood Day Surgery is a registered healthcare provider organisation for the purposes of the **My Health Records Act 2012** (Cth). If you have a ***My Health Record***, Springwood Day Surgery will upload health information about you to your ***My Health Record*** unless you tell us not to by ticking the following box.

☐ NO:

ACKNOWLEDGEMENT

I have read, understood and completed each section of this form and acknowledge my selections by signing below.

NAME:

RELATIONSHIP TO PATIENT IF SIGNING AS SUBSTITUE:

SIGNATURE: DATE:

INTERPRETER DECLARATION (TO BE COMPLETED BY INTERPRETER)

INTERPRETER SERVICE USED: ☐ YES:

Please specify language (below) and if service was provided by: ☐ TELEPHONE: ☐ IN PERSON: ☐ VIDEO CALL:

I declare that I have sight translated this document, in the language specified below, between the patient and the staff member to the best of my ability, and I have advised the health care practitioner of any concerns regarding my performance.

NAME:

LANGUAGE: SIGNATURE:

DATE: TIME: NAATI NO: If applicable

UNABLE TO GAIN PATIENT CONSENT (TO BE COMPLETED BY SPRINGWOOD DAY SURGERY STAFF)

☐ **UNABLE TO GAIN PATIENT CONSENT:**

☐ PATIENT REPRESENTATIVE INFORMED FOR FURTHER DISCUSSION:

DATE:

REASON:

NAME: POSITION: SIGNATURE: