

Patient Details

Which clinics are you attending today:

Title: First Name:

Family Name:

Date of Birth: Gender: Male Female Other

Address:

Postcode:

Phone (Home): (Work): (Mobile):

Email: Occupation:

Emergency Contact: Emergency Contact Number:

Your GP's Name: Telephone:

Are you willing for us to contact the above practitioner to obtain clinically relevant information if required?
 Yes No

Are you willing for us to send a report on your visit/s here to the above practitioner if required?
 Yes No

Medicare Number: Patient ID #:

Do you hold a Concession Card? Yes No Private Health:

[Optometry patients only] Date of last eye exam? At QUT? Other:

Do you identify as Aboriginal and/or Torres Strait Islander: Yes No

How did you find out about QUT Health Clinics?

Please note in signing this form clients acknowledge the QUT Health Clinics Charter of Client Rights and Responsibilities. This document is available from reception and on the QUT Health Clinics website.

The QUT Health Clinics will not tolerate any swearing, aggressive, threatening or other unacceptable behaviour. QUT Health Clinics staff will take appropriate action to address this behaviour to support the safety of all clients, students and staff, which may include contacting QUT Security or the Police.

Please turn over page

RESEARCH

The QUT Health Clinics support research activities and special teaching clinics.

Any research conducted within the clinic must be approved by the QUT Human Research Ethics Committee (HREC), in accordance with the *National Statement on Ethical Conduct in Human Research* (www.nhmrc.gov.au).

Research activities conducted at the clinic may include reviewing patient health records to assist in the development of new research theories or contribute to medical knowledge.

A QUT researcher or research assistant may access your medical records to assess your suitability for a project, if suitable they may contact you to seek your interest in participating in research projects or special teaching clinics. Your participation in this research is optional and will not affect your routine clinical care.

In accordance with the *Information Privacy Act 2009 (Qld)* all information collected in this practice shall be treated as 'sensitive information'. To protect your privacy, this practice operates in accordance with the Act and QUT's Information Privacy Policy (http://www.mopp.qut.edu.au/F/F_06_02.jsp).

Tick below if you do **not** wish to participate:

I do not want my medical record accessed to assess for suitability for research purposes.

I do not wish to be contacted to discuss participation in research.

PRIVACY STATEMENT

All information collected in this practice is treated as 'sensitive information'. To protect your privacy, this practice operates in accordance with the *Information Privacy Act 2009 (Qld)* and QUT's Information Privacy policy (http://www.mopp.qut.edu.au/F/F_06_02.jsp).

We collect and use the information you provide to manage your healthcare. You can assist in maintaining the accuracy of your information by advising the practice of any change to the information you provide, including any change of address, telephone number etc.

Students observing or participating in consultations have signed and are bound by a strict confidentiality agreement. If your record is used as a teaching aide, identifying information will be removed before use.

Your personal information may be disclosed to other health services involved in your healthcare management (for example your GP or other specialists).

Your personal information will not be disclosed to any other third party without your written consent. In some circumstances we are legally obliged to disclose information about you, for example if records are subpoenaed for a court case or there is a legal requirement to collect information about your particular health conditions such as life-threatening diseases or diseases with high public risks, or if there is an immediate and specified risk of harm to an identifiable person or persons which can be averted only by disclosing information. We will ensure that any such disclosure is limited to only what is necessary.

If you have questions regarding the management of your personal information, please ask our staff. If you wish to make a complaint about privacy, please contact the QUT Privacy Officer (privacy@qut.edu.au).

By signing this I acknowledge that I have read and fully understand the above statement. I intend this consent form to cover the entire course of my treatment for present and future conditions.

I, (print name) _____ understand and consent to the above.

Signature: _____ Date: _____

I, (parent/guardian) _____ give consent for treatment by QUT Health Clinics for my child.

(child's name) _____

Thank you for visiting QUT Health Clinics.