Northside Clinic

Patient Consent Form

Please read this consent form carefully prior to signing.

Northside Clinic collects information from you for the primary purpose of providing quality health care. We require you to provide us with your personal details and a full medical history so that we may properly assess, diagnose and treat illnesses and medical conditions, ensuring we are proactive in your health care. To enable ongoing care, and in keeping with the Northside Clinic Privacy Policy, the Privacy Act 1988 and Australian Privacy Principles, we wish to provide you with sufficient information on how your personal information may be used or disclosed and record your consent or restrictions to this consent.

Your personal information will only be used for the purposes for which it was collected or as otherwise permitted by law, and we respect your right to determine how your information is used or disclosed.

The information we collect may be collected by a number of different methods and examples may include: medical test results, notes from consultations, Medicare details, data collected from observations and conversations with you, and details obtained from other health care providers (e.g. specialist correspondence).

By signing below, you (as a patient/parent/guardian) are consenting to the collection of your personal information, and that it may be used or disclosed by the practice for the following purposes:

- Administrative purposes in running our general practice.
- Billing purposes, including compliance with Medicare requirements.
- Follow-up reminder/recall notices for treatment and preventative health care. This may be via phone call, email, SMS or post.
- Disclosure to others involved in your health care, including doctors and specialists outside this medical practice. This may occur through referral to other doctors, or for medical tests and in the reports or results returned to us following the referrals.
- Accreditation and quality assurance activities to improve individual and community health care and practice management.
- For legal related disclosure as required by a court of law.
- For the purposes of research only where de-identified information is used.
- To allow medical students and staff to participate in medical training/teaching using only de-identified information.

- To comply with any legislative or regulatory requirements e.g. notifiable diseases.
- For use when seeking treatment by other doctors in this practice.

Please complete the form below if you understand and agree to the following statements in relation to our use, collection, privacy and disclosure of your patient information.

☐ I have read the information above and understand the reasons why my information must be collected, and the purposes for which my information may be used or disclosed. I understand that if my information is to be used for any purpose other than set out above, my further consent will be obtained.

☐ I give permission for my personal information to be collected, used and disclosed as described above (including contact via telephone, email, postal service and SMS). I understand only relevant personal information will be provided to allow the above actions to be undertaken and I am free to withdraw, alter or restrict my consent at any time by notifying this practice in writing.

Patient Name:
(Please Print) _____

Signature: _____ Date: _____

If not Patient signing –
Your name: (Please Print) _____

Your relationship to patient
(e.g. Mother, Father, Guardian: _____

PRACTICE USE ONLY:

Witnessed by:
(Staff signature) _____ Date: _____

Patient Registration Form

We need this information to provide the best quality care. This form complies with the RACGP standards for general practices. This means your personal health information is kept private and secure, as required by federal and state privacy laws. If you have concerns, please leave blank and discuss with your GP.

Please notify us promptly of any changes in your contact details. Accurate contact details help us identify you and your medical records, and allow us to contact you promptly about tests and results.

These details are collected by Northside Clinic to confirm your identity with Medicare and may be used to confirm your identity when you visit or communicate with the practice.

First Name:
(as on Medicare card) _____

Middle Name: _____

Last Name:
(as on Medicare card) _____

Date of Birth: _____ Gender: (as on Medicare records) __F__M__X__

Address: _____

_____

Admin use only

Entered	Details checked	Date

Medicare card number | | | | | | | | | | |

Number next to your name | | Expiry_____/_____

Health care/Pension card | | | | | | | | | | |

Expiry _____/_____

Dept of Veterans Affairs | | | | | | | | | | |

Expiry _____/_____

Name of School
(full time students only) | |

Student card expiry _____/_____

Mobile: _____ Home: _____ Work: _____

Email: _____

Who can we contact in an emergency?

Name: _____ Relationship to you: _____

Phone: _____

Email: _____

Admin use only

Entered	Details checked	Date

Transfer of Health Information

You may have consistently consulted with a GP at another practice. The health information held by that GP may assist us with your future health care needs. You may wish to have a copy or a summary of your health records transferred to this practice. Please ask the receptionist for information about how this can take place.

How you identify yourself and your culture

Knowing information about your identity and cultural background can help us provide health care that meets your individual needs.

- Providing this information is optional –

Preferred name: _____

Preferred pronouns: ☐ she ☐ he ☐ they ☐ other _____

Gender: _____ Sexual Orientation: _____

Relationship: ☐ De facto ☐ Separated ☐ Divorced ☐ Widowed ☐ Single

☐ Same-sex partner ☐ Married

Occupation: _____

Are you of Aboriginal or Torres Strait Islander origin?

☐ Non indigenous ☐ Aboriginal ☐ Torres Strait Islander

☐ Aboriginal & Torres Strait Islander

Other cultural background: _____
(e.g. Mediterranean, Asian, African)

Country of Birth: _____

Admin use only

Entered	Details checked	Date

Is English your first language? ☐ Yes ☐ No Primary language: _____

If no, do you require an interpreter? ☐ Yes ☐ No

Medicare Australia and MyHealthRecord

Do you have a My Health Record? ☐ Yes ☐ No

If 'No', can we provide you assisted registration to set up your My Health Record? ☐ Yes ☐ No

Are your bank details linked with Medicare? ☐ Yes ☐ No

Name: _____ Date: _____ GP: _____

Your Health Information

Your GP or nurse collect this information to ensure your medical record is accurate and to identify significant preventative health issues.

Are your vaccinations up to date? ☐ Yes ☐ No ☐ Unsure

List allergies and intolerances to medication	Describe your reaction

Admin use only

Entered	Details checked	Date

List regular medications and doses and complementary medications and doses

Do you smoke cigarettes? ☐ Yes ☐ No

If yes, how many do you smoke a day? _____

If no, have you ever smoked a cigarette? ☐ Yes ☐ No

If yes, when did you quit? _____

Do you drink alcohol? ☐ Yes ☐ No

If yes, how many standard drinks would you consume in a week? _____

Have you had a PAP smear in the last 2 years? ☐ Yes ☐ No

If you are over 50, have you had:

A breast screen in the last 2 years? ☐ Yes ☐ No

A test for blood in your stool in the last 2 years? ☐ Yes ☐ No

A prostate check in the last year? ☐ Yes ☐ No

Do you have an advance health plan for end-of-life care? ☐ Yes ☐ No
For more information about this, talk to your GP

Are you an organ donor? ☐ Yes ☐ No

It may not be possible for all of your preventative health issues to be addressed in one consultation. Your doctor may ask you to come back for follow up appointments to manage multiple issues. During your consultation the doctor may prioritise your requests to address any significant health concerns.

Admin use only

Entered	Details checked	Date