CASE FILE #_____

PATIENT CONSENT to PARTICIPATE

Patient Information		
Title:	Gender:	
Patient Family Name:	Date of Birth: _____ /_____ / _____	
Patient First Name:		
Address:		
Town / City:	State:	Postcode:
Telephone (Mobile):	Telephone (Home):	
Email:		

Next of Kin / Emergency Contact	
Name:	
Telephone (Mobile):	Telephone (Home):
Relationship to patient:	

Name of Medical Practitioner (GP) and Contact Details:

Patient Occupation:

How did you find out about this clinic?

☐ Friend / Family of student ☐ Referred by a patient: _____ ☐ CQU Staff Member ☐ CQU Student

☐ Outreach Event_____ ☐ Community Partners ☐ Social Media/Google

Are you of Aboriginal, Torres Strait Islander or South Sea Islander origin? (Tick all that apply)

☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander ☐ Yes, South Sea Islander ☐ No

Do you consent to receive promotional correspondence from CQUniversity Health Clinic? ☐ Yes ☐ No

Do you require an interpreter? ☐ Yes ☐ No

Collection Notice:
Personal information is collected, stored, used, and disclosed by CQUniversity Australia to deliver a range of health services to the general public, within a learning environment for students under clinical supervision by registered health professionals. CQUniversity has the obligation under the *Information Privacy Act 2009* (Qld) to collect this information.

CQUniversity may utilise personal information for research purposes by way of identifiable and de-identified data for the planning and improvement of core services.

Personal information may be disclosed to employees within the CQU Health Network to provide treatment and services to you. Information may also be provided to others involved in your care outside the CQU Health Network such as General Practitioners, specialists, technicians, and laboratories with further express consent.

Information collected can be disclosed without consent when required by law. Any other provision of personal information will be authorised and in accordance with CQUniversity's Information Privacy Policy and Procedure.

CASE FILE #_____

Individuals have the right to access personal information within CQUniversity held about them, subject to any exceptions in relevant legislations. Should any individual wish to seek access to their personal information, they are to contact the Coordinator Records and Privacy via email privacyrti@cqu.edu.au

Consent for consultation recording

Upon signing this consent form, please advise if you give consent for video consultations to be recorded. All recording are stored securely. Access to recordings will be by employees, students, and registered health professionals within the CQU Health Network, to provide treatment and services.

☐ Yes, I give consent for video consultations to be recorded.

☐ No, I do not give consent for video consultations to be recorded.

Consent for clinical education works

Upon signing this consent form, please advise if you give consent for your case history, x-rays, clinical photos, videos and sound recordings being used for clinical education and research purposes, providing that my name is not disclosed in any reports or published educational documents.

☐ Yes, I give consent

☐ No, I do not give consent

By signing this document, I agree to proceed with treatment.

Patient:

Signature: _____

Signature Date: _____ / _____ / _____

By signing this document, I agree to my child proceeding with treatment.

Parent / Guardian:

Signature: _____

Signature Date: _____ / _____ / _____