Patient Details

Please fill in and return in envelope provided

Mr / Mstr / Mrs / Ms / Miss *(please circle)*

SURNAME: .... GIVEN NAMES: ....

DATE OF BIRTH: / / SEX: ☐ MALE ☐ FEMALE

ADDRESS: ....

SUBURB: .... STATE: .... POST CODE: ....

POSTAL ADDRESS (*if different from above*): ....

SUBURB: .... STATE: .... POST CODE: ....

CONTACT NUMBERS

HOME PH: .... WORK PH: ....

MOBILE: .... EMAIL: ....

☐ SINGLE ☐ MARRIED ☐ DEFACTO ☐ WIDOWED ☐ DIVORCED ☐ SEPARATED

HOSPITAL INSURANCE DETAILS

FUND NAME: ....

TABLE: .... MEMBERSHIP NO: ....

MEDICARE NO: ☐☐☐☐ ☐☐☐☐☐ ☐ REF NO: ☐ EXPIRY DATE: ....

CONCESSION OR VETERAN AFFAIRS NUMBER

TYPE: .... NUMBER: .... EXPIRY DATE:..............................

NEXT OF KIN/EMERGENCY CONTACT

NAME: .... RELATIONSHIP: ....

HOME PH: .... MOBILE PHONE: ....

ADDRESS *(if different from above)*: ....

....

REFERRING DOCTOR: ....

REFERRAL DATE: .... / / ☐ .... 3 MONTHS ☐ ......12 MONTHS

☐ .... INDEFINITE

GENERAL PRACTITIONER: ....

ADDRESS: ....

TELEPHONE:

HEIGHT **WEIGHT**

ALLERGIES

Adelaide Oncology & Haematology

Patient Consent Form

Adelaide Oncology and Haematology requires your consent to collect personal information about you. Please read this consent form carefully, tick the applicable boxes, and sign where indicated below.

Adelaide Oncology and Haematology collects such information for the primary purpose of providing quality health care. As a patient of our medical practice, we require you to provide us with your personal details and a full medical history, so that we may properly assess, diagnose, treat and be proactive in your health care needs.

Please place a tick in the following boxes if you consent to this information to be used by Adelaide Oncology and Haematology in the following ways:

☐ I give permission for my personal health information to be used for administrative purposes to assist in the running of Adelaide Oncology and Haematology and for providing quality healthcare, including disclosure to others involved in my healthcare, such as treating doctors and specialists within and outside this Medical Practice.

☐ I give my consent for disclosure of my clinical information (x-rays, biopsy results and clinical management) to be used for discussion with other cancer specialists for the purpose of ensuring the best treatment outcome.

☐ I give my consent to the presence of a third party to be present during my consultation. (This may include a Practice Nurse, medical registrar or another treating doctor).

☐ I understand that by ticking the relevant boxes above that Adelaide Oncology and Haematology is authorised on my behalf to use my relevant personal health information and I am free to withdraw my consent at any time by verbal or written notification.

OR

☐ I am unsure and would like to discuss this further with someone from Adelaide Oncology and Haematology before I sign

<u>CONSENT TO COLLECT CLINICAL INFORMATION</u>

Clinical information collected as part of your routine care may be used for research and quality assurance activities. No information that would allow you to be identified will be stored or used in any reports.

For each specific project that may be undertaken based on this data, we will seek ethical approval from Calvary Health Care Adelaide Human Research Ethics Committee.

If you **DO NOT** wish for your clinical information to be included in future research or quality assurance activities, please tick the box below:

☐ I **DO NOT** consent for my clinical data (or the clinical data of my relative/person for whom I am authorised to represent) to be included for the purposes of research and quality assurance activities.

Patient's Name ____ Date ____/____/____

Patient's Signature ____