Friendly Society Private Hospital

CONSENT AND ACKNOWLEDGEMENT

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F ☐ Other

CONSENT FOR THE COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION

I have received and read the information relating to Personal Information and Privacy for Patients and understand my right to privacy and how my personal information will be used at the Hospital.

I consent to the collection, use and disclosure of my personal information for the purposes set out in it and for any directly related purpose.

I understand that consent for disclosure of personal information to or from other medical practitioners, hospitals or health services providers to assist in current or future treatments that relate to the condition for which I am currently being treated including access to my medical information, medical photographs and records and provision of information following my discharge, is required for me to be treated at the Hospital.

I consent for medical photographs to be made of me for purposes of continuing care and treatment planning.

I am authorised to sign this Form as, or on behalf of, the patient named at the top of this page.

I understand that if I have any concerns about privacy issues, I may raise them when I come to hospital for admission.

USES OF PERSONAL INFORMATION

Note: *If you **DO NOT** wish your personal information to be used for a specific purpose, please tick the box in the column to show you do not give consent.*

Note: *If there is no response against an item it is taken to mean that you agree with that use.*

☐ To train and educate professional staff.

☐ For research and development projects undertaken by the Friendly Society Private Hospital or in conjunction with related research organisations and external research organisations with which we collaborate or partner.

☐ To assist in the development of service delivery and planning facilities.

☐ To assist the Friendly Society Private Hospital in undertaking quality improvement activities.

☐ To inform you about fundraising activities.

☐ To communicate marketing initiatives to you.

DISCLOSURES OF PERSONAL INFORMATION

☐ To advise hospital affiliated associations and services of your presence in the hospital, e.g. RSL, Veterans Affairs Associations, Ministers of Religion, etc. if applicable.

☐ To your family/carer to communicate your condition or discharge arrangements (where necessary).

DECLARATION

Signature of Patient/Parent/Guardian

Date

Name of Parent/Guardian

Relationship to Patient

DO NOT WRITE IN THIS BINDING MARGIN

CONSENT AND ACKNOWLEDGEMENT

MR 3

Patient Name:	UR Nº :	DOB:

PROPERTY AND VALUABLES

I acknowledge that:

1. The hospital does not take any responsibility for the loss of any items I keep with me during my hospitalisation.
2. The hospital has recommended that I do not keep any jewellery, credit cards, cash (in excess of $50.00) or other valuables with me whilst I am a patient in this hospital.
3. I will arrange for any valuables in my possession to be taken home upon my admission to the hospital, or if that is not possible, I will store valuables in my hospital room safe.
4. The hospital has the right to sell or otherwise dispose of any property, including valuables, which I leave in the possession of the hospital for more than 3 months after the date of my discharge.
5. I will notify the staff of any valuables brought into or removed from the hospital after admission.

Signature of Patient/Parent/Guardian

Date

Name of Parent/Guardian

Relationship to Patient

RIGHTS AND RESPONSIBILITES

I have read the information relating to my Rights and Responsibilities.

I understand these Rights and Responsibilities and agree to abide by my responsibilities in relation to my admission to the hospital.

I am aware I can discuss any queries I have with the staff.

Signature of Patient/Parent/Guardian

Date

Name of Parent/Guardian

Relationship to Patient

MEDICAL ADVICE

I am aware that for 24 hours following my procedure (and thereafter as directed by my doctor):

- I should not drive a motor vehicle, operate machinery or engage in any sport, work or lifting.
- I should not conduct business, sign legal documents or make important decisions.

I have made arrangements for a responsible adult/carer to collect me from the hospital and stay with me overnight.

Signature of Patient/Parent/Guardian

Date

Name of Parent/Guardian

Relationship to Patient

DO NOT WRITE IN THIS BINDING MARGIN →