*Please complete this prior to your medical appointment*



**USQ Health Service Patient Details Form**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Student Number: Staff External to USQ | | | | | | | | | | | | | | |
| Title: | First Name: | | Middle Name: | | | | | | Surname: | | | | | |
| Date of Birth: / / | | | | | | | | | | | | | | |
| Female Male Intersex/Transgender/Other (please describe) ……………………………………… | | | | | | | | | | | | | | |
| Gender Identity:  Female Male Non-binary/Gender-X/Intersex/Indeterminate/Other | | | | | | | | | | | | | | |
| Do you identify as Australian Aboriginal and/or Torres Strait Islander? | | | | | | | | | | | | | | |
| Known as (if applicable): | | | | | | | | | | Marital Status: | | | | |
| Country of Birth: | | | | | If not born in Australia, year of arrival: | | | | | | | | | |
| Languages Spoken: | | | | | | | | | | Preferred Language: | | | | |
| Do you require an interpreter for: Hearing Impairment Language | | | | | | | | | | | | | | |
| Residential Street Address: | | | | | | | | | | | | | | |
| Suburb: | | | | | | State: | | | | | | | | Postcode: |
| Email (USQ email preferred): | | | | Mobile: | | | | | | | | Landline: | | |
| Postal Address if different to Residential Address: | | | | | | | | | | | | | | |
| Suburb: | | | | | | State: | | | | | | | | Postcode: |
| Medicare Number: \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ | | | | | | | IRN #: \_ \_ | | | | | | Expiry: \_ \_ /20\_ \_ | |
| Dept of Veterans’ Affairs (DVA) Number: | | | | | | | | White/Gold: | | | | | Expiry: / /20\_ \_ | |
| Health Care Card (HCC)/Pension (Concession) Number: \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ | | | | | | | | | | | | | Expiry: / /20\_ \_ | |
| Overseas Student Health Cover (OSHC) (For International students / staff only) | | | | | | | | | | | | | | |
| Provider Name: | | | | Number: | | | | | | | | | Expiry: / /20\_ \_ | |
| Next of Kin Name: | | | | Relationship to You: | | | | | | | | Phone: | | |
| Emergency Contact (if different to Next of Kin) | | | | | | | | | | | | | | |
| Contact Name: | | | | Relationship to You: | | | | | | | | Phone: | | |
| Usual Medical Practice/Doctor: | | | | Suburb/Town: | | | | | | | | Phone: | | |
| Current Medications: | | Known Allergies: | | | | | | | | | Previous Vaccinations: | | | |

**Please see over the page**

Document Title: Patient Details Form

Reviewed by: Health Service Manager

Version 8.0 Date: September 2020

Review Date: September 2021

# Consent Form

The Health and Wellness team offer a variety of supports and professionally trained staff to assist you in your learning journey. This form is collecting information for the purpose of the services that we provide. The quality of our services relate to a best-practice model of multidisciplinary teamwork whereby staff within the Service may consult with one another to discuss various aspects of your support. All staff of the Service will have access to your personal information (which may include appointment and/or clinical notes) and student records. Your health and psychological records are stored separately and are only accessible by authorised staff members. Staff will only access your personal information, health records and/or appointment notes when it is required as part of an assessment, diagnosis (if necessary) and intervention of your presenting issue. We are committed to protecting your privacy and this form ensures that you understand the conditions of our Service.

Our Service will opt to communicate with you via email, SMS, or phone unless you advise us otherwise.

For a full understanding of our privacy information and management of your personal information, please access the Service Privacy Statement located in our waiting rooms or at http://www.usq.edu.au/student-support, in addition to the USQ Privacy Statement located at https://www.usq.edu.au/privacy/privacy-statement.

We require your consent to collect personal information about you and to use the information you provide in the following ways:

* Administrative purposes in running the USQ Health Service.
* Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
* Disclosure to others involved in your healthcare including treating Practitioners and specialists outside the USQ Health Service. This may occur though referral to other practitioners, or for medical investigations and in the reports or results returned to us following referrals.
* Disclosure to other doctors in the USQ Health Service, locums etc. attached to the service for the purpose of patient care and teaching.
* For research and quality assurance activities to improve individual and community health care and practice management. Usually information that does not identify you is used but, should information that will identify you be required, you will be informed and given the opportunity to “opt out” of any involvement.
* To comply with any legislative or regulatory requirements e.g. Notifiable diseases.
* For reminder and recall letters, emails, SMS or phone calls which may be sent to you regarding your health care and management.

You can decline to have your health information used in all or some of the ways outlined above but it may influence our ability to manage your health care to provide the best outcome for you.

**Cancellation Policy**

Patients who need to cancel or postpone an appointment must contact the Service via telephone or email prior to the scheduled appointment. There are times when we are unable to provide a service to you. We reserve the right to appoint or change a practitioner if your regular practitioner is unavailable. If you require assistance that is not within the scope of our services, we will support you by offering a referral to an external practitioner.

**Please Note:** If, after reading this you are at all unsure of what is written, please discuss it with the staff member you are seeing for services. Failure to consent to these conditions may result in our inability to provide a service to you.

I confirm that I have read and understood the above principles in conjunction with the Privacy Statement. I agree to these conditions for the services provided by the Careers and Employability; Social Justice, Equity and Inclusion; and Health and Wellness teams.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Patient Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Person giving consent Signature Date

(if different from patient, e.g. Parent, Carer)

**Office use only**

|  |  |  |
| --- | --- | --- |
| Received by: | Date: | Entered by: |

Document Title: Patient Details Form

Reviewed by: Health Service Manager

Version 8.0 Date: September 2020

Review Date: September 2021