IUIH Goodna Clinic

13 Church street Goodna QLD 4300 Ph: 3436 9600 Fax: 3818 8030

Email: Goodn.Reception@IUIH.org.au

IUIH Goodna Mums & Bubs Clinic

Shop 6B 12 Queen street Goodna QLD 4300 Ph: 3437 8975 Fax: 3288 3662



***IUIH CLINIC***

***GPs in Schools Consent Form***

*Please have this form filled & returned to your school before \_\_\_\_\_/\_\_\_\_\_/ 2021*

*School:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Grade:\_\_\_\_\_\_\_\_\_*

 *I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****(your name)***

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****(Signature)***

*give permission for my child \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****(child name)***

*to see an IUIH Doctor at my school.*

*Best time for my appointment is* ***(please Circle)***

 ***Morning Afternoon Anytime***

***I give Permission for my child to have a Hearing Screening YES / NO***

# cid:image001.png@01D05732.CA6348B0 NEW CLIENT FORM IUIH Goodna CLINIC

|  |
| --- |
| **PERSON TO CONTACT IN CASE OF EMERGENCY** |
| NAME |  |
| PHONE NUMBER |  |
| ADDRESS |  |
| RELATIONSHIP TO YOU |  |
| **NEXT OF KIN**IF SAME AS EMERGENCY CONTACT, WRITE ‘AS ABOVE’ |
| NAME |  |
| PHONE NUMBER |  |
| ADDRESS |  |
| RELATIONSHIP TO YOU |  |

|  |
| --- |
| TITLE: MR | MRS | MS| MISS| MASTER |
| **FIRST NAME** |  |
| **MIDDLE NAME** |  |
| **LAST NAME** |  |
| PREFERRED NAME |  |
| DATE OF BIRTH |  |
| ABORIGINAL | TORRES STRAIT ISLANDER |BOTH | NEITHER (Family Of ATSI) (Circle one) |
| OTHER |  |
| **IF NEITHER, NAME IMMEDIATE FAMILY MEMBER WHO IS****IUIH GOODNA CLIENT & ATSI** |  |
| COUNTRY OF BIRTH |  |

|  |
| --- |
| **LIST DEPENDANTS (UNDER 18 YRS OLD)** |
| **NAME** |  |
| MEDICARE REF # |  |
| DATE OF BIRTH |  |
| ABORIGINAL | TORRES STRAIT ISLANDER |BOTH | NEITHER (Circle one) |
| RELATION TO YOU |  |
| CONCESSION CARD #EXPIRY | / / |
| ALLERGIES |  |
| **NAME** |  |
| MEDICARE REF # |  |
| DATE OF BIRTH |  |
| ABORIGINAL | TORRES STRAIT ISLANDER |BOTH | NEITHER (Circle one) |
| RELATION TO YOU |  |
| CONCESSION CARD #EXPIRY | / / |
| ALLERGIES |  |
| **NAME** |  |
| MEDICARE REF # |  |
| DATE OF BIRTH |  |
| ABORIGINAL | TORRES STRAIT ISLANDER |BOTH | NEITHER (Circle one) |
| RELATION TO YOU |  |
| CONCESSION CARD #EXPIRY | / / |
| ALLERGIES |  |

|  |  |
| --- | --- |
| MEDICARE CARD NUMBER |  |
| REFERENCE NUMBER |  |
| EXPIRY DATE | / |
| CONCESSION TYPE | DVA/PENSION/HCC |
| CARD NUMBER |  |
| START DATE | / / |
| END DATE | / / |

|  |
| --- |
| **RESIDENTIAL ADDRESS** |
| STREET |  |
| SUBURB |  |
| STATE & COUNTRY |  |
| POST CODE |  |
| **POSTAL ADDRESS, IF DIFFERENT FROM ABOVE** |
| STREET |  |
| SUBURB |  |
| STATE & COUNTRY |  |
| POST CODE |  |

|  |  |
| --- | --- |
| HOME NUMBER |  |
| WORK NUMBER |  |
| MOBILE NUMBER |  |
| PREFERRED CONTACT | H | W | M |

DO YOU CONSENT TO RECEIVING SMS APPOINTMENT NOTIFICATIONS FROM IUIH Goodna Clinic ? YES| NO WOULD YOU LIKE A STAFF MEMBER TO ASSIST YOU TO REGISTER FOR MYHEALTH RECORD? YES| NO

DO YOU HAVE ANY ALLERGIES? YES| NO PLEASE LIST:

# cid:image001.png@01D05732.CA6348B0PRIVACY & CONSENT

In accordance with the *Information Privacy Act 2009* our practice respects your rights to privacy. We realise that it is important that you understand the purpose for which we collect details about your health, as well as how this information is used at our practice and to whom this information might be disclosed.

The official formal criteria used by the Australian Government and most State Governments developed in consultation with Aboriginal / Torres Strait Islander (ATSI) peoples are set out in the following formula;

## An Aboriginal / Torres Strait Islander person must meet the following three (3) criteria:

1. ***Must be of Aboriginal and/or Torres Strait Islander descent;***
2. ***Must identify as an Aboriginal and/or Torres Strait Islander person; and***
3. ***Must be accepted as an Aboriginal and/or Torres Strait Islander person in the community in which they live.***

The policy of our practice is to follow these procedures:

1. The information collected will be used for the purpose of providing treatment to you. Personal information such as your name and address will be used for the purpose of processing payment and writing to you about any issues affecting your treatment.
2. We may disclose your health information to other health care professionals, or require it from them, in our judgement that is necessary in the context of your treatment. In that event the disclosure of your personal details will be minimised wherever possible.

We may also use parts of your health information for research purposes, in study groups or at seminars as this may provide benefit to other patients. Should that happen, your personal identity would not be disclosed without your consent to do so.

1. Your medical history, treatment records, and any material relevant to your treatment will be kept electronically in a secure environment at the Clinic. You may inspect or request copies of our records of your treatment at any time, or seek an explanation.
2. If any of the information we have about you is inaccurate, you may ask us to alter our records accordingly. You can otherwise rest assured that your health information will be treated with the utmost confidentiality. Disclosure will not be made to any person not involved in either your treatment or the administration of this practice, without your prior written consent. If you have any queries or concerns about our handling of your health information, please do not hesitate to raise these concerns with our practice. Otherwise, please sign this form as confirmation that you have read and understood our privacy policy, and consent to the use of your health information in this way.
3. It is important that you clearly indicate your ethnicity (refer to over page), due to bulk billing processes).

SIGNED

……………………………………………………… PRINT NAME

………….……………………………………………

 DATE / /