mater health

PATIENT REGISTRATION

Unit Record No. _____

Surname _____

Given Names _____

DOB _____ Sex _____

AFFIX PATIENT IDENTIFICATION LABEL HERE

CNQ0002

Office Use Only	Medical consent:	Date: / /	Staff:

Admission Details

Admission date: / / Time: : ☐ AM ☐ PM	Admission type: ☐ Day ☐ Overnight
Admitting hospital:	Operation date: / /
MATERNITY admission (if applicable): Dr	Admitting Doctor: Dr
Expected date of delivery (if applicable): / /	

Previous Admission

Have you been a patient in the last 3 months? ☐ Yes ☐ No

If YES, only complete name, date of birth details and sign the declaration on the Patient Registration form (all remaining pages must be completed)
If NO, please complete all sections.

Patient Details

Title:	Surname:	Previous name (if applicable)
First name:		Middle name:
Sex: ☐ Male ☐ Female		Date of birth: / /
Residential address (not postal address):		
Suburb:	State:	Postcode:
Home phone:	Work phone:	Mobile:
Email address:		
Marital status: ☐ Married/Defacto ☐ Never married ☐ Divorced ☐ Separated ☐ Widowed		
Religion:	Country of birth:	Resident: ☐ Yes ☐ No
Do you identify as Aboriginal or Torres Strait Islander? ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander ☐ Yes, both Aboriginal and Torres Strait Islander ☐ No ☐ Declined to answer		
Do you identify as Australian South Sea Islander? ☐ Yes ☐ No		
Interpreter required: ☐ Yes ☐ No If *Yes*, what is your preferred language:		
Medicare card number:	Reference:	Valid to: /
Occupation:		
DVA number:		DVA card colour: ☐ Gold ☐ White
Referring GP:	Practice:	
Usual/local GP:	Practice:	

Hospital Account (please select one of the options below)

☐ **Private Health Fund**	Fund name: Member number: Have you confirmed that you are covered for this procedure? ☐ Yes ☐ No Will an excess apply? ☐ Yes ☐ No Amount: $ Will a co-payment apply? ☐ Yes ☐ No Amount: $ Have you been with your health fund for 12 months? ☐ Yes ☐ No
☐ **Australian Defence Force**	☐ Army ☐ RAAF ☐ Navy Rank: Unit: EP ID: Defence approval number:
☐ **Workcover/Third Party Liability**	Have you lodged a claim yet? ☐ Yes ☐ No If *Yes*, claim number: Date of accident: / / Accident location:
☐ **DVA** (Department of Veteran's Affairs)	
☐ **Self-insured/ overseas**	Have you been given an estimate of hospital fees? ☐ Yes ☐ No If *No*, please contact the Mater for an estimate of hospital fees and charges: Townsville: (07) 4727 4444 Bundaberg: (07) 4153 9539 Mackay: (07) 4965 5666 Rockhampton: (07) 4931 3476
☐ **Other**	Details:

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mater health

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Concession Cards

Without the provision of correct and complete details the patient is advised that they will be billed the full amount and must take responsibility for later claiming from Medicare and/or the appropriate provider.

☐ Pension Card	Number:		Valid to: ... / ... / ...
☐ Health Care Card	Number:		Valid to: ... / ... / ...
☐ Commonwealth Seniors Health Card	Number:		Valid to: ... / ... / ...
☐ Pharmacy Safety Net	Number:		Valid to: 31 / 12 / ...

Postal Address

Address:		
Suburb:	State:	Postcode:

Next Of Kin

Title:	Surname:	Given name(s):	
Address:			
Suburb:		State:	Postcode:
Home phone:	Work phone:	Mobile:	
Email address:		Relationship to patient:	

Emergency Contact (other than next of kin)

Title:	Surname:	Given name(s):	
Address:			
Suburb:		State:	Postcode:
Home phone:	Work phone:	Mobile:	
Email address:		Relationship to patient:	

Past Hospital Details

Have you been in hospital in the last 28 days? ☐ Yes ☐ No	Have you been in hospital in the last 7 days? ☐ Yes ☐ No
If *Yes*, please name the hospital(s):	
Dates of hospitalisation: ... / ... / ... to ... / ... / ...	Public or Private patient: ☐ Public ☐ Private
Reason for hospitalisation:	
Have you ever been a patient at Mater Hospital before? ☐ Yes ☐ No	If *Yes*, name of hospital: ...

Declaration

I certify that the above information is true to the best of my knowledge and agree to its release in support of my insurance claim.

Signature:	Date:

Nursing Staff Use Only	Ward:	Bed:	Admission time: ... : ... ☐ AM ☐ PM
	Admitting diagnosis:		
	Has patient presented at another hospital in the last 7 days? ☐ Yes ☐ No If *Yes*, name of hospital: ... Date of admission from: ... / ... / ... to ... / ... / ...		
	Was the patient transferred in? ☐ Yes ☐ No ☐ A&E ☐ Admitted		
Administrative Staff Use Only	Visit number:	Pre-admission clerk:	Date: ... / ... / ...

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MEDICATION SUMMARY

Unit Record No. _____

Surname _____

Given Names _____

DOB _____ Sex _____

AFFIX PATIENT IDENTIFICATION LABEL HERE

MW0038

Please complete this form in **BLOCK LETTERS** as best you can with as much detail as possible.

Whilst you are a patient at Mater we will endeavour to ensure all medications prescribed for you are safe and appropriate. An important part of this process is to have an accurate record of all medication you are already taking. Please complete the following list taking care to include all prescribed, over the counter, herbal and vitamin products. If you have any problems completing the list please contact your GP or community pharmacy for assistance.

Medication	Strength	Dose	Frequency	Reason for taking?	Taking for how long?
e.g. Aspirin	100mg	1 daily	Daily	Thin blood	2 years

Medications STOPPED in the past 2 weeks

Medication	Strength	Dose	Frequency	Reason for taking?	When/why stopped?
e.g. Warfarin	5mg	1 daily	Daily	Heart valve	1 Dec - doctor told me to stop taking

Mater may need to contact your local healthcare providers to obtain or provide information (e.g. Safety Net number or values, preadmission medication, discharge medication summary). If you consent to this, please provide contact details for the following health care providers.

Retail/community pharmacy:
Respite or home nursing service:

In order to ensure an uninterrupted supply of your regular medicines during your stay in hospital, please remember to bring in ALL your medications in their original labelled containers and/or repeat prescriptions with you upon admission. Please include all eye drops, patches, natural/complimentary medicines or topical products.

Charges for medication provided during your stay in hospital may be billed to your pharmacy account according to the agreement between your private health fund and Mater. Not all pharmacy items may be covered by your health fund. In this case your pharmacy account may need to be paid on discharge or an account will be forwarded to you by mail for payment within 14 days of discharge.

The information I have provided here is accurate and complete to the best of my knowledge.

Patient/Parent/Substitute decision-maker signature: **X**	Date:

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MEDICATION SUMMARY

10/20
Ver. 2.00
MW0038

mater health

PATIENT HISTORY AND NURSING ASSESSMENT

Unit Record No. _____

Surname _____

Given Names _____

DOB _____ Sex _____

AFFIX PATIENT IDENTIFICATION LABEL HERE

CNQ0003

- Please read questions carefully and place tick in the appropriate box. Use space provided for any further information.
- **Note:** shaded areas for **staff only**. If *Yes* response, follow prompts.

Information obtained from: ☐ Patient ☐ Relative ☐ Carer ☐ Other *(specify)*: ..... Name: .....

Admission Details

Admission date: ... / ... / ... Time: ... : ... ☐ AM ☐ PM

Reason for admission:

Symptoms leading to admission (including duration):

If injury – Place of occurrence: .....

Activity at time of occurrence: .....

When was the last admission to any hospital – Date of admission: ... / ... / ...

Hospital: .....

Is today's admission related to a previous admission? ☐ Yes ☐ No

If *Yes*, reason: .....

Information provided to patient (refer to Patient Information folder located in patient room):

- ☐ Rights and responsibilities Initial: .....
- ☐ Compliment/complaints process Initial: .....
- ☐ 10 tips for safer healthcare Initial: .....
- ☐ Pain has been assessed and managed Initial: .....
- ☐ SHARED/M.A.T.E.R./Reach Initial: .....

Patient goal: .....

Inform NUM and complete incident if required.

Enduring Power of Attorney/Advanced Health Directive

Do you have an Advanced Health Directive? ☐ Yes *(please provide copy)* ☐ No

Do you have an Enduring Power of Attorney ☐ Yes *(please provide copy)* ☐ No

If *Yes* – Name: ..... Contact number: .....

Photocopy the original or certified copy, date and sign copy. File copy in health record.

Allergies and Reactions

Please document any known allergies or reactions (e.g. medications, sticking plaster, iodine, x-ray dyes, seafood, eggs, peanuts or fruit).

Are you allergic to latex? ☐ Yes ☐ No

If *Yes*, reaction: .....

Refer to policy if noted to be allergic to latex.

Food allergy? ☐ Yes *(provide details)* ☐ Nil known

Food	Reaction

Include on diet list.

Are you allergic to any medications? ☐ Yes *(provide details)* ☐ Nil known

Medication name	Reaction

Apply adverse drug reaction (ADR) sticker to medication chart and ALLERGY ID band.

Past Surgical/Medical History

Year	Surgical/medical condition	Year	Surgical/medical condition	Year	Surgical/medical condition

Previous anaesthetic problem (self/family): ☐ Yes ☐ No

If *Yes*, provide details: .....

Advise Anaesthetist and document in *'Progress Notes'*.

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PATIENT HISTORY AND NURSING ASSESSMENT

mater health

PATIENT HISTORY AND NURSING ASSESSMENT

Unit Record No. _____

Surname _____

Given Names _____

DOB _____ Sex _____

AFFIX PATIENT IDENTIFICATION LABEL HERE

General Health and Wellbeing *(continued)*

Do you have, or have you in the past, had a problem with? *(tick to indicate YES)*

☐ Fits/faints/"funny turns"	When:	Initiate discharge planning. (CQ) consider implementing TOP 5, complete cognition screening tool.
☐ Limb paralysis	Where:	
☐ Speech problems	Details:	
☐ Epilepsy	Last seizure: ..... / ..... /	
☐ Polio/meningitis	When:	
☐ Short term memory loss/confusion/dementia	Details:	
☐ Migraines/headaches	Management:	
GASTROINTESTINAL	Name of specialist(s):	
☐ Gastric ulcer/reflux	Details:	Consider referral to Dietitian. (NQ) consider referral to Stoma Therapy Nurse.
☐ Hiatus hernia	Details:	
☐ Hepatitis	Type:	
☐ Jaundice		
☐ Diarrhoea		
☐ Constipation		
☐ Stoma	Details:	
☐ Nausea/vomiting		
GENITOURINARY	Name of specialist(s):	
☐ Dialysis	Details:	☐ If for *bowel preparation*, notify treating Medical Officer
☐ Renal impairment/"kidney trouble"	Details:	
☐ Kidney/bladder problems/incontinence	◯ Incontinence ◯ Frequency ◯ Urgency ◯ Pain	☐ Implement management plan Consider falls risk assessment.
☐ Stoma	Details:	
MUSCULOSKELETAL SYSTEM	Name of specialist(s):	
☐ Arthritis	Details:	**Note:** Cytotoxic precautions may need to be implemented depending on type of medicines prescribed (e.g. methotrexate).
☐ Back or neck injury or problems	Details:	
☐ Pins, plates, implants or devices	Details:	
ENDOCRINE	Name of specialist(s):	
☐ Diabetes	◯ Type 1 ◯ Type 2	Consider Dietitian/Diabetic Educator review.
☐ Low blood sugar	◯ Insulin ◯ Insulin pump ◯ Tablets ◯ Diet ◯ Injections	
☐ Thyroid problems	Details:	
HAEMATOLOGY	Name of specialist(s):	
☐ Blood disorders/bleeding problems/ clotting disorders	Details:	
☐ Anaemia		
☐ Previous blood transfusions	When:	
☐ History of an adverse reaction to any blood product	Reaction:	☐ Notify treating Medical Officer
Do you take blood thinning/arthritis or aspirin based medicine? ☐ Yes ☐ No If *Yes*, details: ..... Have you ceased this medicine? ◯ Yes ◯ No Date last taken: ..... / ..... /		☐ Advise Anaesthetist if patient is for surgery ☐ Advise Medical Officer

mater health

PATIENT HISTORY AND NURSING ASSESSMENT

Unit Record No. _____

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AFFIX PATIENT IDENTIFICATION LABEL HERE

Risk Assessment

Venous thromboembolism risk assessment

Have you ever had a blood clot in your legs or lungs? ☐ Yes ☐ No If *Yes*, details:		☐ Notify treating Medical Officer regarding interventions ☐ Complete VTE risk assessment

Nutrition

1. Have you lost weight recently (over the past 6 months) without trying? ☐ Yes – how much weight have you lost: ◯ 1–5kg *(1)* ◯ 6–10kg *(2)* ◯ 11–15 kg *(3)* ◯ Over 15 kg *(4)* ◯ Unsure *(5)* ☐ No *(0)* ☐ Unsure *(2)*	**Total MST score** *(question 1 + 2)*	If MST score is ≥2, refer to Dietitian. ☐ Complete *'Waterlow Assessment'*
2. Has your appetite decreased recently? ☐ Yes *(1)* ☐ No *(0)*		
Do you need a special or modified diet? ☐ Yes ☐ No If *Yes*, details:		☐ Notify catering department ☐ Update computer/diet list Consider referral to Dietitian.

Falls risk assessment

Are you over the age of 65 years? ☐ Yes ☐ No	☐ Complete falls risk assessment tool Implement fall prevention strategies/ education to patient. ☐ (CQ) falls alert sign
Have you had a fall or falls in the last 6 months? ☐ Yes ☐ No If *Yes*, how often:	
Does you past or current medical condition place you at risk of a fall? ☐ Yes ☐ No If *Yes*, details:	

Waterlow pressure injury risk assessment

Does your past or current medical condition place you at risk of a pressure ulcer? ☐ Yes ☐ No If *Yes*, location:	High risk – implement Waterlow Risk Interventions.
Have you had a previous pressure ulcer? ☐ Yes ☐ No	

Infection control

Have you been transferred from another hospital/long-term facility with a length of stay ≥24 hours? ☐ Yes ☐ No If *Yes*, where:	☐ **(CQ) complete the *'Multi-Resistant Organism Screening Tool'*** ☐ Notify Infection Control/Unit Manager/ Hospital Supervisor ☐ Complete appropriate wound documentation ☐ Complete *'CJD Risk Group Assessment Corp'* **If patient is undergoing eye, neuro *OR* spinal surgery,** notify Infection Control Manager *OR* Hospital Nurse Manager.
Do you work in or have you been admitted overnight in another hospital/long-term facility in the last 6 months? ☐ Yes ☐ No If *Yes*, where:	
Are you undergoing treatment that requires frequent admissions to a health care facility (e.g. chemo, dialysis)? ☐ Yes ☐ No If *Yes*, details:	
Have you ever had an infection with a multi-resistant bacteria (e.g. golden staph, MRSA, VRE)? ☐ Yes ☐ No If *Yes*, what year:	
Have you travelled overseas in the last month? ☐ Yes ☐ No If *Yes*, location:	
Do you have a wound? ☐ Yes ☐ No If *Yes*, location:	
Have you had neurosurgery prior to 1990? ☐ Yes ☐ No If *Yes*, details:	
Have you taken human pituitary hormone (growth hormone, gonadotrophin) prior to 1986? ☐ Yes ☐ No	
Does anyone in your family have CJD (Creutzfeld-Jakob Disease)? ☐ Yes ☐ No If *Yes*, details:	
Have you been identified as potentially CJD after a surgical procedure or shown you a medical letter regarding their risk for CJD? ☐ Yes ☐ No	
Have you ever had Tuberculosis? ☐ Yes ☐ No	
Have you ever had a blood borne infection (e.g. Hepatitis B or C, HIV)? ☐ Yes ☐ No	

Psychosocial

Name of specialist(s):	
Depression/mental illness/learning disorders? ☐ Yes ☐ No If *Yes*, details:	

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PATIENT HISTORY AND NURSING ASSESSMENT

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DOB _____ Sex _____

AFFIX PATIENT IDENTIFICATION LABEL HERE

General Health and Wellbeing

Weight: ..... kg Height: ..... cm BMI *(weight [kg]/height [m²])*:	If >120 kg/BMI >35, refer to policy.
Do you smoke? ☐ Yes ☐ No If *Yes*, how many per day? ..... If *No*, have you smoked in the past? ☐ Yes ☐ No Ceased date: ..... / ..... /	Smoking laws explained/information given by: .....
Do you drink alcohol? ☐ Yes ☐ No If *Yes*, standard drinks per day?	Consider commencing alcohol withdrawal documentation.
Do you use illicit or recreational drugs? ☐ Yes ☐ No	
Do you have chronic pain? ☐ Yes ☐ No If *Yes*, where:	Commence hospital pain scoring system to assess pain.
Immunisations: ☐ Yes ☐ No	Patient advised to update: ☐ Yes ☐ No
(Female patients) Are you pregnant? ☐ Yes ☐ No Specialist: ..... Due date: ..... / ..... /	

Do you have, or have you in the past, had a problem with? *(tick to indicate YES)*

CANCER	Name of specialist(s):	
☐ Cancer	Site: ..... Year diagnosed: ..... Treatment: ◯ Chemo – last treatment date: ..... / ..... / ..... ◯ Surgery ◯ Radium	If currently having treatment implement the appropriate precautions.
☐ Family history of cancer	Details:	
DERMATOLOGY	Name of specialist(s):	
☐ Skin condition(s)	Details:	High risk – implement pressure injury risk interventions throughout the document, complete incident entry and *'Wound Assessment'* form.
☐ Pressure ulcer(s)	Where:	
RESPIRATORY	Name of specialist(s):	
☐ Bronchitis/Asthma/Emphysema/COPD/ Shortness of breath/Bronchiectasis/Asbestosis	Do you use: ◯ Nebulisers ◯ Home oxygen ◯ Puffers	Check if documented on *'Medication Chart'*.
☐ Disturbed sleep patterns/problems/snoring	Details:	☐ Sedation required ☐ Pain Frequency of disturbances: ..... ☐ CPAP machine to be brought into hospital
☐ Sleep apnoea	◯ CPAP	
☐ Breathing problems	Details:	
☐ Other chest problems	Details:	Consider referral to physiotherapist.
CARDIOVASCULAR	Name of specialist(s):	
☐ High blood pressure	☐ Yes ☐ No	
☐ Chest pain, angina	☐ Yes ☐ No	
☐ Heart attack(s)	Year(s):	
☐ Heart failure/congestive cardiac failure	☐ Yes ☐ No	
☐ Elevated cholesterol/triglycerides	☐ Yes ☐ No	
☐ Rheumatic fever/valve disease	☐ Yes ☐ No	
☐ Palpitations/heart murmur/irregular heart beat	Details:	Possible high falls risk – complete falls risk assessment/implement falls prevention interventions.
☐ Family history of cardiac disease	Details:	
☐ Other related problems (e.g. arterial/venous ulcers)	Details:	
☐ Do you have a pace maker or implantable defibrillator?	Details: ..... Date last checked: ..... / ..... /	Surgeon informed: ☐ Yes ☐ No Anaesthetist informed: ☐ Yes ☐ No
NEUROLOGY	Name of specialist(s):	
☐ Multiple sclerosis, Motor neurone disease (MND), Parkinson's disease, stroke, TIA	Details: ..... Diagnosed: ..... / ..... /	Possible high falls risk – complete falls risk assessment/implement falls prevention interventions.
☐ Any residual weakness	Where:	

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PATIENT HISTORY AND NURSING ASSESSMENT

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Risk Assessment *(continued)*

Special needs

Primary language: ..... Interpreter required? ☐ Yes ☐ No

Language barriers: .....

.....

.....

Telephone Interpreter Service, Google Translate, Ward Communication Tool.

Cultural considerations? ☐ Yes ☐ No

If *Yes*, details: .....

.....

Implement strategies to include cultural requirements.

Visual issues? ☐ Limited sight ☐ Impairment ☐ Blindness ☐ No

If *Yes*, details: .....

☐ Glasses ☐ Contact lenses ☐ Eye prosthesis ☐ Other *(specify)*: .....

Aids present on admission: ☐ Yes ☐ No

Walking aids? ☐ Yes ☐ No

If *Yes*, details: .....

.....

Aids present on admission: ☐ Yes ☐ No

☐ Complete falls risk assessment

Hearing issues? ☐ Yes ☐ No

If *Yes*, details: .....

.....

Hearing aids: ☐ Left ☐ Right

Other aids/communication tool: .....

Aids present on admission: ☐ Yes ☐ No

Do you have any loose teeth, chipped teeth, fillings? ☐ Yes ☐ No

If *Yes*, details: .....

.....

Have you had any recent dental treatment? ☐ Yes ☐ No

If *Yes*, details: .....

.....

Any crowns/caps/dentures/braces? ☐ Yes ☐ No

If *Yes*, details: .....

.....

Dentures:

Upper: ☐ Partial ☐ Full

Lower: ☐ Partial ☐ Full

Present on admission: ☐ Yes ☐ No

Discharge Planning

Do you live alone? ☐ Yes ☐ No

Do you live in a: ☐ House ☐ Unit/flat ☐ Retirement village ☐ Hostel ☐ Nursing home

☐ Other *(specify)*: .....

Discuss possible post discharge needs with patient/carer.

Refer to *'Discharge Planning'* policy.

Do you have problems caring for yourself at home? ☐ Yes ☐ No

If *Yes*, details: .....

Who will care for you on discharge? .....

Is this person in good health and able to assist? ☐ Yes ☐ No

Are you the carer for someone else? ☐ Yes ☐ No

Notify Discharge Planner, if applicable

Date: ..... / ..... / .....

Do you require help with your medications at home? ☐ Yes ☐ No

Do you currently use any community services? ☐ Yes ☐ No

If *Yes*, which service: ☐ OzCare ☐ Blue Care ☐ Home Help ☐ Meals

☐ Other *(specify)*: .....

☐ Contact Community Service regarding admission

Proposed length of stay: ..... days

Discharge time is 10am for inpatients – can someone collect you by this time? ☐ Yes ☐ No

If *Yes*, name of person: .....

If *No*, how do you plan to get home? .....

Discuss discharge time of 10am with patient/carer.

If transport required – document in notes.

Surgical patients ONLY

Who will care for you on discharge?

Name: ..... Relationship: .....

Home phone: ..... Mobile phone: .....

Transport arrangements: .....

.....

.....

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PATIENT HISTORY AND NURSING ASSESSMENT

Unit Record No. _____

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DOB _____ Sex _____

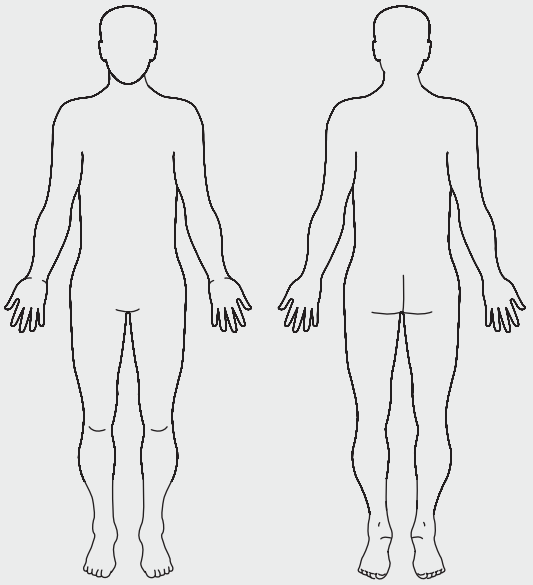
AFFIX PATIENT IDENTIFICATION LABEL HERE

Patient history form completed/reviewed by Preadmission Clinic *(if applicable)*		
Name (print):	Signature:	Date:

Admitting Nurse completed/reviewed information and sign prior to planning care		
Name (print):	Signature:	Date:

Presentation on Admission (initiate appropriate nursing intervention(s), document issue action and outcome in notes)

Assessment attended: ☐ Yes – Signature: ..... Time: ..... : ..... ☐ Nil present

Physical appearance	Symbol	Observation
Identify observations with the use of symbols (right) on the below illustration. 	P	Pain ☐ Yes – Pain score: ..... /10
	#	Fracture (if present, complete appropriate compartment syndrome or neurovascular documentation)
	PA	Pressure area
	U	Ulcer
	ST	Skin tears (Complete *'Wound Assessment'* form)
	W	Wound
	S	Swelling/oedema
	R	Rash
	B	Bruise
	D	Drains
	IV	Intravascular device including IVT, port-a-cath, CVC etc.
	SC	Subcutaneous line
	IDC	Indwelling catheter – Type: ..... Date last changed: ..... / ..... / .....
	E	Enteral feeding (e.g. N/G/PEG feeds)
	O	Ostomy – Type: .....
	LA	Limb amputation – Prosthesis: ☐ Yes ☐ No
	Oth	Other *(specify)*: .....

Additional comments:

Mental status: ☐ Orientated ☐ Vague ☐ Confused ☐ Other *(specify)*: .....

Emotional status: ☐ Calm ☐ Anxious ☐ Distressed ☐ Other *(specify)*: .....

Medications: Documented on *'Medication Chart'* (include all medications including over the counter and supplements, complete MMP)

Valuables description	Destination	Returned to patient
	☐ Sent home ☐ With patient ☐ Safe	
	☐ Sent home ☐ With patient ☐ Safe	
	☐ Sent home ☐ With patient ☐ Safe	
	☐ Sent home ☐ With patient ☐ Safe	
	☐ Sent home ☐ With patient ☐ Safe	
	☐ Sent home ☐ With patient ☐ Safe	

mater health

PATIENT INFORMATION CONSENT FORM

Unit Record No. _____

Surname _____

Given Names _____

DOB _____ Sex _____

AFFIX PATIENT IDENTIFICATION LABEL HERE

MW0028

Mater and its subsidiaries ("Mater") acknowledges its privacy obligations to patients under the *Privacy Act 1988* and is seeking your acknowledgement to the ways in which Mater may use and disclose your personal and health information.

Further information on our privacy practices can be viewed at https://www.mater.org.au/group/privacy

The Mater Patient Charter, which outlines your rights and responsibilities, can be viewed at https://www.mater.org.au/group/patient-charter or by scanning the QR code.

Mater may use your information:

» To provide healthcare to you

» To perform administrative tasks associated with providing healthcare to you such as making appointments and processing accounts

» For quality improvement, service management, education and research purposes, however this will not include any identifying information about you.

Mater may disclose your information:

» To your GP, referring health professional or external healthcare services to support your ongoing care

» To your substitute decision maker or next of kin, if you do not have capacity to provide consent yourself, so they can make health care decisions on your behalf

» To update the *My Health Record* national health record system, unless you ask us not to do this by ticking this box ☐.

» To any agency that may be paying for your healthcare

» To students supervised by Mater clinicians who are directly involved in providing healthcare to you

» To authorised agencies for safety and regulatory purposes where you receive a medical device or prosthesis as part of your treatment

» Where it is otherwise required or authorised by law.

Mater may access your information:

» From other healthcare providers, pathology laboratories, diagnostic imaging providers and the My Health Record for the purpose of providing healthcare to you unless you withdraw your consent at those agencies for doing so.

Mater may contact you:

» In relation to Mater services and products that may be relevant to you

» To seek your feedback

» To invite you to participate in research associated with Mater researchers and/or clinicians

» To invite you to support Mater through Mater Foundation

» To invite you to receive Mater communications

» At any time, you can change the way you receive communications from Mater or opt out of communications. If you do not want to receive communication relating to the services listed above, please tick this box ☐.

Acknowledgement

I acknowledge that:

» I have read, understood and agree with the way my personal and health information will be used and disclosed as explained in this form

» Mater may use my contact details to contact me

» The security of some communication methods may be outside the control of Mater e.g. email, internet and other digital methods

» I am able to change my consent and restrict disclosure of my information at any time by contacting the Mater Privacy Office.

Patient/parent/substitute decision-maker name (please print):

Signature:	Date:

Relationship to patient (if substitute decision-maker, indicate basis of authority e.g. Power of Attorney):

Binding margin - do not write. Do not reproduce by photocopying.
All clinical form creation and amendments must be conducted through Health Records.

PATIENT INFORMATION CONSENT FORM

07/21
Ver. 2.00
MW0028

Interpreter declaration on page 2 ➲

mater health

PATIENT INFORMATION CONSENT FORM

Unit Record No. _____

Surname _____

Given Names _____

DOB _____ Sex _____

AFFIX PATIENT IDENTIFICATION LABEL HERE

Interpreter declaration (to be completed by Interpreter)

Interpreter services used: ☐ Yes

Please specify language *(below)* and if service was provided by: ☐ Telephone ☐ In person ☐ Video call

I declare that I have sight translated this document, in the language specified below, between the parent/career/substitute decision-maker and the staff member to the best of my ability, and I have advised the health care practitioner of any concerns regarding my performance.

Language:		
Name:	NAATI no.:	
Signature:	Date:	Time:

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