

MONASH UNIVERSITY HEALTH SERVICES

Patient details & consent form

PERSONAL CONTACT DETAILS *Please fill in the form below with the patients details.*

First name: _____	Last name: _____	
Preferred name <i>(eg, nickname, chosen name) - if applicable:</i> _____	Date of birth <i>(Day/Month/Year):</i> / /	
Preferred Email Address: _____	Mobile Phone: _____	
Residential Address - Street Number & Name <i>(in semester):</i> _____	Suburb: _____	Postcode: _____

SEX, GENDER & CULTURAL BACKGROUND

What was your sex recorded at birth (birth sex)? <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Unknown <input type="checkbox"/> Prefer not to say <input type="checkbox"/> Another term <i>(please let your practitioner know during your next consult)</i>	How do you describe your gender? <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Non-binary <input type="checkbox"/> Gender diverse <input type="checkbox"/> Transgender <input type="checkbox"/> Prefer not to say <input type="checkbox"/> Another term <i>(please let your practitioner know during your next consult)</i>
What are your preferred pronouns? <i>Select all that apply</i> <input type="checkbox"/> She/Her/Hers <input type="checkbox"/> He/Him/His <input type="checkbox"/> They/Them/Theirs <input type="checkbox"/> Other - please let us know your preferred pronouns here: _____	Are you of Aboriginal or Torres Strait Islander origin? <i>You may let us know this at any time.</i> <input type="checkbox"/> Yes, Aboriginal <input type="checkbox"/> Yes, Torres Strait Islander <input type="checkbox"/> Yes, Aboriginal/Torres Strait Islander <input type="checkbox"/> Prefer not to say <input type="checkbox"/> No, Other Cultural Background <i>please let us know below:</i> <input type="checkbox"/> Other <input type="checkbox"/> Eurasian <input type="checkbox"/> Asian <input type="checkbox"/> African <input type="checkbox"/> European <input type="checkbox"/> Caucasian <input type="checkbox"/> Creole

INTERNATIONAL STUDENTS/OVERSEAS VISITORS ONLY

Overseas Student Health Care (OSHC) Fund:

Allianz Bupa Medibank ahm NIB Other (Please specify): _____

Policy Number:

Expiry Date:

IHI Number (required for electronic prescription & to upload immunisations to the Australian Immunisation Register):

8003 _____

AUSTRALIAN RESIDENTS ONLY (MEDICARE CARD HOLDERS)

Medicare Card Number:

Medicare Card Reference #:

Medicare Card Expiry Date:

Do you have a DVA Card?

No Yes, Gold Card. Yes, White Card.

DVA Card Number (if applicable):

Do you have a Centrelink issued Health Care Card?

No Yes, Health Care Card. Yes, Newstart.

Yes, Aged Pension Card. Yes, Disability Pension Card.

Yes, Carer Pension Card.

If yes:

Pension card number: _____ Reference number: _____

Pension card expiry: _____

STUDENT/STAFF/VISITOR

Are you a Monash University Student/Staff/Visitor?

Please choose one.

Student Staff Visitor

Are you a Monash College Student?

No Yes N/A

Monash University Student/Staff ID Number (if applicable):

Faculty/Department (if applicable):

Art & Design Arts Business & Economics
 Education Engineering Information Technology
 Law Medicine, Nursing & Health Sciences
 Pharmacy and Pharmaceutical Sciences Science
 Other: _____

EMERGENCY CONTACT INFORMATION - IN MELBOURNE (We collect this information in case of an emergency)

First name:

Last name:

Contact Number:

Relationship:

CONSENT

I consent to receive appointment reminders, recall messages and appointment related emails and SMS.

Yes No

I acknowledge that there is a fee for doctors appointments for staff and visitors.

I acknowledge that if I have a procedure, dressing or vaccination, I may be charged an additional fee (this will be discussed with you beforehand). You may have to pay a private fee for your doctor's appointment if you're having a procedure, but you can claim a refund from Medicare afterwards.

Yes No

Consent for the Collection of Personal Information:

Monash University Health Services (UHS) conducts medical practices on each of the campuses. We collect information from you in accordance with the UHS Data Protection and Privacy Collection Statement (*scan QR code below to read in full*) for the primary purpose of providing healthcare services to you. We need to record your personal details and a full medical history so that we may properly assess, diagnose, treat and be proactive in your healthcare needs.



Please read this information carefully, and if you agree, sign where indicated below. It's possible that you may not be in full agreement and this needs to be discussed with the practitioner you are seeing.

Accredited medical practices are required to operate systems for the recall of people with abnormal results and the routine reminder of people for health maintenance reasons. These recall and reminder notices will be sent via SMS or to your last stated home address.

I have read the information above UHS Data Protection and Privacy Collection Statement and understand the reasons why my information must be collected.

I understand that I am not obliged to provide any information requested of me, but that my failure to do so might compromise the quality of the health care and treatment given to me.

I am aware of my right to access the information collected about me, except in some circumstances where access might legitimately be withheld. I understand I will be given an explanation in these circumstances.

I consent to the handling of my information by this practice for the purposes set out above and in accordance with the UHS Data Protection and Privacy Collection Statement, subject to any limitations on access or disclosure that I notify.

I notify the UHS of the following limitations of my information:

I agree to these terms

Signed: _____

Date: _____