

Resident Consent form for Individual Enhanced Primary Care items

Residential Aged Care Facility	Name: _____
Resident	Name: _____ Date of Birth: _____
Person responsible (if resident is unable to give consent)	Name: _____ Contact number: _____
Usual General Practitioner (s)	Name: _____ Contact number: _____ Name: _____ Contact number: _____

It has been identified by _____ (requesting health care provider) that the resident named above would benefit from the following medical assessment(s).

- | | |
|--|--|
| <input type="checkbox"/> Comprehensive Medical Assessment | <input type="checkbox"/> GP contribution to Care Plan |
| <input type="checkbox"/> Residential Medication Management Review | <input type="checkbox"/> Case Conference |

For these assessments to be undertaken, the health care provider needs your consent. Enclosed is an information leaflet entitled *New Medicare Services for Residents*, which explains these assessments in detail.

Resident Consent

I, (resident/person responsible) consent to the release of my/my relative's relevant personal health information from the Residential Aged Care Facility (stated above) to appropriate health care providers. I acknowledge that this information will be used for the purposes of assessing my medical care needs and for the provision of ongoing comprehensive health care. I understand that all information obtained will be kept confidential and that the information contained on this form will not be disclosed to any other individual or organisation (unless they are directly related to my care) without my consent.

I understand that all information obtained from these assessments will be kept confidential and not be disclosed to any other individual or organisation (unless they are directly related to my relative's care) without my consent.

I understand that I am free to withdraw my consent at any time and understand that such withdrawal will not influence my treatment or my relationship with my General Practitioner and the Residential Aged Care Facility. I understand that if I do wish to withdraw my consent I need to contact the facility manager.

I acknowledge receipt of a copy of this consent form and the information leaflet entitled, *New Medicare Services for Residents in Residential Aged Care Facilities (Enhanced Primary Care Initiative)*.

Please tick: **Yes** **No** **I consent to the assessments selected above, being undertaken.**

Signature of Resident/Person responsible: _____ Print: _____

Date: _____ Relationship to resident: _____

Signature of person obtaining consent: _____ **Print:** _____

Date: _____

I understand that if I have any questions relating to my consent I should contact the Facility Manager on (insert phone number).

After you have signed the form please fax it to (insert fax number) or post to (insert postal address).

With regards,

(Signature of requesting health provider)