



PATIENT DECLARATION

SURNAME.....GIVEN NAME.....

AFFIX LABEL HERE

ADDRESS

DATE OF BIRTH..... SEX

Consent for the collection & Use of Personal Information

The main purpose for collecting and using information is to provide you with the best possible healthcare. We must also comply with the laws that require us to collect or disclose personal information about you.

If you have a My Health Record we can access this to provide you with the best possible care and upload your discharge brochure unless otherwise stated.

Other uses of personal information are set out below. If you do not want us to use your personal information in one of these ways, please tick the box next to that item.

Uses of Personal Information	YES	NO
To inform my next of kin the outcome of treatment and discharge instructions.		
To train and educate staff		
To send me confidential surveys to obtain my feedback as to the quality of care I received during my stay		

Disclosure of Personal Information	YES	NO
To other medical practitioners or health care providers to assist in my current or future treatment that relates to the condition I am being treated for		
To my next of kin as stated above		

Day Surgery Agreement

I confirm that have been advised of the special nature of Day Surgery and have been instructed in the following terms with regard to my undergoing surgery at The Eye Hospital:

1. **I AGREE:**

- To be accompanied home by a responsible person.
- I should rest for at least 12-24 hours and arrange for someone to stay with me in case assistance is needed.
- If I have general anaesthetic or sedation I should not drive a motor vehicle and am aware I may not be covered by insurance in the case of an accident.
- NOT to drink alcohol for 24 hours before and after my anaesthetic.
- To follow the written instructions provided to me.
- It is in my best interest not to make important decisions, operate complex or dangerous equipment, or do anything that requires me to be alert and coordinated for 24 hours after general anaesthetic or sedation.

2. I understand that in the event of any post-operative complications arising from my surgery or anaesthetic, I should contact my surgeon or attend the Emergency Department at the LGH.
3. I acknowledge that the hospital accepts no responsibility for the loss of any money or valuables I bring with me.
4. I consent to the collection, use and disclosure of my personal information for the purposes set out above

NAME..... DATE:/...../.....

SIGNATURE

Relationship to patient (If not patient).....

PATIENT DECLARATION