Please COMPLETE & RETURN to:

P.O. Box 293, Spring Hill, QLD, 4004

FAX: (07) 3236 9855 | Email: info@qldeye.com

(Please return at least 1 week prior to the procedure)

Queensland Eye Hospital Consent Form

Patient Details (Below fields MUST be completed prior to patient and doctor signing)

Patient Name		**Date of Birth**	
Address			
Doctor		**Date of Procedure**	
Procedure (Rooms to complete)			

Doctor's Statement

I have discussed the above surgical procedure including the risks of possible loss of sight and life threatening complications, and have given this patient the opportunity to discuss any matter relating to this procedure that the patient feels is relevant.
I request that pre-operative treatment be commenced on admission as per my Therapeutic Pathway.

Doctor Name ______________________ (Print) **Signature** ______________________ (Doctor Sign) **Date**___ /___ / ___

Patient Consent

- I have been fully informed of the nature, likely results and material risks of the above surgical procedure.
- I understand that I (or the patient who I am consenting for) may not drive home, drive or operate heavy machinery for 24 hours, nor make any legal decisions for 24 hours following this surgical procedure.
- I understand that any surgical procedure carries some risk and my doctor has explained the risks associated with my procedure.
- I understand that while all professional, legal and moral duty of care is given to me during this surgical procedure, I may not get the expected result.
- I understand that additional procedures may be required on the day should the treating doctor have unexpected findings and I agree to this as long as the additional procedure(s) is related to the surgical procedure described above.
- I have had the opportunity to ask questions concerning this surgical procedure and the administration of anaesthesia, and have received satisfactory answers and information.
- I understand that I may withdraw my consent at any time prior to the surgical procedure commencing.
- In the event of a staff member injuring and exposing themselves to my blood, or any other body fluid, I hereby give consent for a blood sample to be collected and tested for infectious diseases.
- In the event of an unplanned complication during surgery which requires a hospital transfer, I consent for Queensland Eye Hospital arranging ambulance transfer to a tertiary hospital.

☐ ***I have read*** and understood the meaning of this consent
☐ This consent has been ***read to me*** and I understand its meaning
☐ This consent has been ***translated to me*** and I understand its meaning

Print Name ______________________________ **Patient / Parent / Guardian / Other** (circle)

Signature ______________________________ **Date** ____ /____ / _____

Witnesses (Two signatures required if this consent has been READ or TRANSLATED to me)

Name ______________________ **Signature** ____________________ **Date** ___ /___ / ___

Name ______________________ **Signature** ____________________ **Date** ___ /___ / ___

Interpreter's Statement (Required if consent TRANSLATED for the patient)

I have given a sight translation in _____________ ***(language)*** of the consent form and assisted in the provision of any verbal and written information given to the patient / parent / guardian or other by the doctor.

Interpreter ____________________ **Signature** ____________________ **Date** ___ /___ / ___

Queensland Eye Hospital

Consent Form

Financial Consent

- I acknowledge full responsibility for accounts rendered by Queensland Eye Hospital being theatre charges and accommodation.
- I understand I am liable for all charges associated with my procedure and will pay all costs not reimbursed by private health insurance or other health care providers.
- I acknowledge that I will also receive accounts from each doctor (surgeon / anaesthetist / pathologist) involved with my procedure.
- I understand that if I require admission for further care at a tertiary hospital, I will be responsible for the costs incurred. Uninsured patients who require hospital admission for further care and do not wish to incur further costs may be admitted to a public hospital as a public patient.

Privacy Consent

Queensland Eye Hospital will collect, use and disclose your personal information to provide quality health care. Medical, nursing, allied health and support staff involved in your care may also require access to your personal information to provide health care and perform administrative tasks (bookings, billing and admissions). We may also disclose your personal information to pathology or imaging companies where your doctor has asked for tests to be performed.

A discharge summary, to support continuity of care, will ordinarily be provided to your referring doctor by your surgeon. Please advise your surgeon if you do not wish the discharge summary to be released.

We use your personal information for billing and debt recovery. This may require disclosure of your personal information to your health insurer, Medicare or DVA to process your claim.

If you choose to not provide personal information this may compromise the quality of the health care and treatment we are able to provide. We use de-identified patient information to manage the hospital activities include risk management, safety and security, quality assurance, and accreditation with our licensing authorities.

A copy of our Privacy Policy can be obtained from reception if you wish to examine our privacy practices and your rights in relation to accessing and correcting your personal information.

Personal Information is also used to:

- Train and educate professional staff, where use of de-identified information is not sufficient.
- Invite me to participate in health and medical research projects undertaken solely or in conjunction with related and external research organisations with which we collaborate or partner.
- Assist in the improvement of patient care and Hospital facilities.

Declaration and Consent

- I have read and understood the information in this document and consent to the collections, uses and disclosures as described in this document.
- I understand if I have any concerns about privacy I can raise them when I come to the hospital for admission.
- I consent to QEH contacting me using email / telephone numbers provided on the Patient Details Form if required.

☐ ***I have read*** and understood the meaning of the ***Financial*** and ***Privacy*** consent.

Print Name ______________________________________ **Patient / Parent / Guardian / Other** (circle)

Signature ____ **Date** _____ /_____ / ______