PATIENT DECLARATION

SURNAME……………………..…………GIVEN NAME…………
AFFIX LABEL HERE
ADDRESS ………………………………………………………..
DATE OF BIRTH……………… SEX ………

FORM 20 PATIENT DECLARATION

Consent for the Use and Disclosure 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.

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 indicate in the box by circling Yes or No.

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

Disclosure of Personal Information	Consent	
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	Yes	No
To my next of kin as stated above	Yes	No

Day Surgery Agreement

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

1. **I AGREE:**
    a. To be accompanied home by a responsible person.
    b. I should rest for at least 12-24 hours and arrange for someone to stay with me in case assistance is needed.
    c. If I have a 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.
    d. NOT to drink alcohol for 24 hours before and after my anaesthetic.
    e. To follow the written instructions provided to me
    f. 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

………………………………………… ……………………………………… ………/….…/……
Patient/Representative Name Signature Date

Relationship to Patient (If representative) ………………………………………………………..