Email (only if email consent has been provided):
reception@woundinnovations.com.au
Fax: 07 3059 6030

wound innovations

Patient Information & Consent Form (all sections must be completed)

Appointment Type:

☐ **Onsite consultation** ☐ **Telehealth video consultation** ☐ **Telephone consultation** ☐ **In-home consultation**

Preferred telehealth system: ☐ Zoom ☐ Neo Rehab ☐ Skype* ☐ Facetime*

***Please provide user name for Skype or Facetime:** _____

Please indicate who is paying for this appointment: ☐ Facility/Home care provider ☐ Self-funded/Family-funded

Patient Information

Patient Surname: _____ **Given Names:** _____

D.O.B: _____ **Gender:** ☐ Male ☐ Female ☐ Other (or rather not say)

RACF or Home Care provider name (if relevant): _____

Primary contact at RACF/HCP for this resident: _____

Address: _____ **Unit Name:** _____

Suburb: _____ **State:** _____ **Postcode:** _____

Contact number: _____ **Fax Number:** _____

Medicare Card No: _____ **Ref No:** _____ **Expiry:** _____

Next of Kin: _____ **Relationship:** _____ **Contact No:** _____

Do you have an Enduring Power of Attorney? ☐ Yes ☐ No **EPOA Contact:** _____

Please provide name/s and email addresses for Correspondence and Wound Management Plan to be sent to:

Contact Name: _____ **Contact No:** _____

Contact Name: _____ **Contact No:** _____

If this appointment is for a home care patient, please give contact details of who is currently tending to the wound:

Contact Name: _____ **Contact No:** _____

Is your GP aware of this referral to Wound Innovations? ☐ Yes ☐ No

GP Practice Name: _____ **GP Contact Name:** _____

Email Address: _____ **Medical Objects Ref:** _____

Contact No: _____ **GP Fax No:** _____

Medication, Medical history and Wound images

- I have attached the patient's full medical history and medication chart ☐ Yes ☐ No
- I have selected a telephone consultation and have emailed the patients wound images to reception@woundinnovations.com.au ☐ Yes ☐ No

Please note: RACF & Community provider patient's appointment cannot be booked unless full medical history and medication chart is supplied at the same time as this referral.

Wound Information **Please supply a brief description of the wound/s to be seen (i.e. wound location, duration of wound and current treatment)**

Number of wounds you require Wound Innovations to assess 1 ☐ 2 ☐ 3 ☐ 4-6 Please go to **Section B**

Location of each wound #1 _____ #2 _____ #3 _____

Size of each wound

	Length mm	Width mm	Depth mm
#1			
#2			
#3			

How long has each wound been present?

	Weeks	Months
#1		
#2		
#3		

How did each wound occur?
#1 _____
#2 _____
#3 _____

Current treatment plan for each wound
#1 _____
#2 _____
#3 _____

Is there any other service involved in this patient's wound care? _____

Patient Information Consent

Wound Innovations is a consultancy service and does not hold clinical governance over an individual's care. As this is the case Wound Innovations requires all individuals that are referred to have a General Practitioner (GP) with whom Wound Innovations will regularly liaise regarding the individual's care. As a consultancy service, Wound Innovations clinicians will not take on the day to day care of individuals that are referred. With this in mind it is important that the individual being referred has a local nursing/medical service or is able to independently manage their own wound or has a competent person available to follow the plan provided by Wound Innovations.

Wound Innovations must take reasonable steps to keep your personal information safe and secure from unauthorised access, modification or disclosure and also against misuse and loss. However, transmitting your information by email has risks that you should consider and we require your consent. By giving consent, you agree to the conditions for the use of email communication. Our privacy policy is available on our website at https://www.woundinnovations.com.au/privacy-policy/

You can change your consent at any time by contacting us on **1300 WOUNDS** or **07 3724 0100** or by emailing us at **reception@woundinnovations.com.au.** There will be no effect on our service provision if you withdraw your consent.

By signing this form you consent to your health information to be shared with other health care providers, including your GP or specialist and your home care provider/aged care facility. You also consent to any items below marked 'Yes'.

Do you consent for de-identified clinical photographs to be used for research, education and training purposes? ☐ Yes ☐ No

Do you consent for Wound Innovations staff to undertake procedures such as: general wound care, wound debridement and to take samples such as skin biopsies and wound swabs? ☐ Yes ☐ No

Do you give consent for email communication?
(Please read the terms and conditions at https:// www.woundinnovations.com.au/website-terms-of-use/) ☐ Yes ☐ No

Do you give consent for your clinical consultation to be delivered via telehealth video conferencing or via telephone consultation? ☐ Yes ☐ No

I, _____ consent to be treated by Wound Innovations and have read and fully understand (or have been explained) the information herein.

Signature: _____ Date: _____

Signed by Patient, Patient's Enduring Power of Attorney

Or if the patient or the patients EPOA has given verbal consent please complete the below:

Verbal consent gained from _____ on the _____

EPOA or Patient's name *Date*

_____ Signature: _____

Name and Job title of person who gained consent

Complete this section ONLY if you have more than 3 wounds in need of treatment

Section B – Wound Information for more than 3 wounds

Location of each wound

#4 #5 #6

Size of each wound

#4 Length mm Width mm Depth mm

#5 Length mm Width mm Depth mm

#6 Length mm Width mm Depth mm

How long has each wound been present?

#4 Weeks Months

#5 Weeks Months

#6 Weeks Months

How did each wound occur?

#4

#5

#6

Current treatment plan for each wound

#4

#5

#6

Additional Information