

Patient Referral Form

Please complete this form and return to Wound Innovations by fax 07 3059 6030. Alternatively, this form can be returned to reception@woundinnovations.com.au only if the patient or the patient's legal personal representative have signed the attached consent form.

Location (must be completed)

Spring Hill, Q Residential Aged Care Facility Telehealth Community visit

Title: _____ **Surname:** _____ **Given Name/s:** _____

D.O.B: _____ **Gender:** _____

Address: _____

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

Preferred contact number: _____ **Alternative contact number:** _____

Indigenous status: Aboriginal Torres Strait Islander Both Neither

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

DVA Card No.: _____ **Ref. No.:** _____ **Expiry:** _____

Pension Card No.: _____ **Ref. No.:** _____ **Expiry:** _____

Private Health Fund: _____ **Card No.:** _____ **No.:** _____

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

Do you have an Enduring Power of Attorney or Advanced Health Directive? Yes No

If yes, please give details (i.e. name of EPOA): _____

Emergency Contact: _____ **Relationship:** _____ **Contact No.:** _____

GP Name: _____ **Contact No.:** _____ **Practice Name:** _____

RACF or Home Care _____ **Contact No.:** _____

Provider Contact Name: _____ **Email Address:** _____

What is the current problem? (i.e. where is your wound, how long have you had it, current treatment)

Your medical history (current and/or previous conditions):

Smoker/per day: Stroke Mobility: Incontinence

Diabetes High cholesterol Active walking Other*:

Peripheral Arterial Disease Kidney Disease Needs assistance * Please give details here or attach separate documents

Hypotension Malignancy Full hoist transfer

Your current medications:

Analgesics Dermatological drugs Nutritional supplements

Anti-infectives Immunomodulators or antineoplastic Other*:

Anticoagulant or antiplatelet Rheumatological drugs * Please give details here or attach separate documents

Cardiovascular

Consent Form – Email Communication

Wound Innovations must take reasonable steps to keep your personal information, including your medical records, safe and secure from unauthorised access, modification or disclosure and also against misuse and loss. Transmitting your information by unsecured or unencrypted email has a number of risks that you should consider. We do not encourage these modes of communication for personal information. Wound Innovations requires your consent if you wish to communicate with us via unencrypted or unsecured email. By signing this form on Page 1, you agree to the conditions for the use of email communication.

You can change your communication choice 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 service provision by Wound Innovations if you withdraw your consent.

Risk of using unencrypted or unsecured communication

These include, but are not limited to, the following:

- Wound Innovations cannot guarantee that any particular unsecured email will be received by us
- Email can be circulated, forwarded, stored in paper and electronic files
- Email senders can easily misaddress an email or email can be received by unintended recipients
- Backup copies of email may exist even after the sender or the recipient has deleted his or her copy
- Employers and online services have a right to archive and inspect email transmitted through their systems
- Email can be intercepted, altered, forwarded or used without authorisation or detection
- Email can be used to introduce viruses into computer systems

Conditions for the use of unsecured or unencrypted communication

- You acknowledge that Wound Innovations cannot guarantee but will use reasonable means to maintain security and confidentiality of email information sent and received. However, because of the risks outlined above, Wound Innovations cannot guarantee the security and confidentiality of unsecured or unencrypted email communication, and Wound Innovations will not be liable for the inadvertent disclosure of confidential information sent or received via unsecured or unencrypted email.
- You will not communicate with Wound Innovations via email for urgent or emergency situations.
- You will not use email for communication regarding sensitive medical information.
- Wound Innovations will not use email in place of a consultation with you.
- You will inform Wound Innovations of email address changes.
- You are responsible for informing us of any types of information that you do not want sent by email.
- You understand that email communications between you and Wound Innovations may be recorded on your file.
- Wound Innovations clinical and/or administration staff may receive and read or respond to your messages.
- Wound Innovations will not forward patient-identifiable emails outside of Wound Innovations without your prior written consent, except as authorised by you or required by law. Please refer to Wound Innovations' Privacy Policy.
- You are responsible for protecting your password or other means of access to email. Wound Innovations is not liable for breaches of confidentiality caused by you or any third party.

Patient Consent Form

Please select either Yes or No for each point below. By signing this form you consent to any items marked Yes. You can withdraw your consent to the sharing of your personal information at any time by writing to Wound Innovations at reception@woundinnovations.com.au.

- Do you consent for your health information to be shared with other health care providers, including your general practitioner or specialist and your approved home care provider/aged care facility, to provide you with best ongoing treatment and management of your health related condition?

Yes No

- Do you consent for students to provide services to you under the direct supervision of Wound Innovations qualified health practitioners?

Yes No

- A comprehensive health assessment will be required which may involve taking photographs. Subsequent photographs may be required to monitor the progress of your wound. Due care will be taken to avoid any distinguishing features that may reveal your identity when a photograph is taken. All photographs will be stored securely and confidentially in your health record. Do you consent to the use of photographs?

Yes No

- Clinical information and photographs are valuable tools for education, health research and planning health care needs. Do you give consent for your de-identified photographs and health information to be used for the above purposes including publications, presentations and research?

Yes No

- De-identified photographs and health information to be used for the above purposes including publications such as brochures, webpage and social media. Do you consent for your de-identified clinical information and photographs to be used for marketing and service promotion?

Yes No

- Wound Innovations undertakes research to contribute to the body of knowledge in the specialty area of wounds.

Do you consent for your details to be kept on the research database and reviewed for possible participation in research projects? Yes No

Do you consent to being contacted about research projects relevant to your health condition for the purpose of improving wound services? Yes No

I, _____, consent to be treated by Wound Innovations and have read and fully understand (or have been explained) the information herein. I further consent to the sharing of my personal information and to use email communication (see previous page).

Signature: _____

Date _____

Patient or Patient's enduring power of attorney (select one)