

# STUDENT HEALTH SERVICES - EDITH COWAN UNIVERSITY JOONDALUP

(PLEASE PRINT CLEARLY WHEN COMPLETING THIS FORM & HAND TO RECEPTIONIST WHEN COMPLETE)

|   |                            |  |     |               |                                     |  |                         |                                   |             |           |         |
|---|----------------------------|--|-----|---------------|-------------------------------------|--|-------------------------|-----------------------------------|-------------|-----------|---------|
| Title   | <i>(please circle one)</i> | Mr   | Mrs | Miss          | Ms                                  | Dr.                                    | Prof.                   | Male                              | Female      |           |         |
| Surname/Family name   |                            |  |     |               |                                     |  |                         |                                   |             |           |         |
| First Name  |                            |  |     |               |                                     |  |                         |                                   |             |           |         |
| Date of Birth   |                            | Country of Birth:                                    |     |               |                                     |  |                         |                                   |             |           |         |
| Address <i>(please include Postcode)</i>  |                            |  |     |               |                                     |  |                         |                                   |             |           |         |
| Phone number  |                            | Home   |     | Work          |                                     |  | Mobile                  |                                   |             |           |         |
| Email address   |                            |  |     |               |                                     |  |                         |                                   |             |           |         |
| Medicare number   |                            |  |     |               |                                     | Ref. no. <i>(next to name on card)</i> |                         | Expiry Date                       |             |           |         |
| Pension number  |                            |  |     |               |                                     |  |                         | Expiry Date                       |             |           |         |
| Health Care Card Number   |                            |  |     |               |                                     |  |                         | Expiry Date                       |             |           |         |
| Private Health Fund<br><i>(Australian resident)</i>   |                            |  |     |               |                                     | Membership no.                         |                         | Expiry Date                       |             |           |         |
| OSHC Insurance<br><i>(International Students &amp; Visitors)</i>  |                            | <i>(please specify Fund)</i>                         |     |               |                                     |  | Membership no.          |                                   | Expiry Date |           |         |
| Emergency contact/Next of Kin<br><i>(Name &amp; telephone no. of person we can contact if needed)</i>             |                            |  |     |               |                                     |  |                         |                                   |             |           |         |
| Student Number :  |                            | Course enrolled:                                     |     |               | Staff Number :                      |  | Department              |                                   |             |           |         |
| If employed – where   |                            |  |     | Full time     |                                     | Part time                              |                         | Casual <i>(please circle one)</i> |             |           |         |
| Marital Status <i>(please circle)</i>   |                            | Single   |     | Married       |                                     | Divorced                               |                         | Defacto                           |             | Separated | Widowed |
| <b>Current Medications</b>  |                            | <b>(please list all &amp; include vitamins etc.)</b> |     |               |                                     |  |                         |                                   |             |           |         |
| <b>Do you have any allergies or sensitivities?</b>  |                            | NO or <b>(if YES please list)</b>                    |     |               |                                     |  |                         |                                   |             |           |         |
| Height .....cms   |                            | Weight.....kgs                                       |     | Smoker YES/NO |                                     |  | Alcohol consumer YES/NO |                                   |             |           |         |
| If you identify with any particular cultural background please specify:   |                            |  |     |               |                                     |  |                         |                                   |             |           |         |
| To Assist with health initiatives – are you Aboriginal or Torres Strait Island? <i>(please circle)</i>            |                            |  |     |               |                                     |  |                         |                                   |             |           |         |
| Aboriginal  |                            | Torres Strait Islander                               |     |               | Aboriginal & Torres Strait Islander |  |                         |                                   |             |           |         |
| Any other relevant information<br>(e.g. please state if you do not wish to be contacted at home by phone or mail) |                            |  |     |               |                                     |  |                         |                                   |             |           |         |

**Please carefully read & sign Privacy Consent Form over >>>**

Jan '12

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## ***Patient Consent Form***

The Edith Cowan University Student Health Service requires your consent to collect personal information about you. Please read this information carefully, and sign where indicated below.

The health service collects information from you for the primary purpose of providing quality health care. We require you to provide the service with your personal details and a full medical history so that we may properly assess, diagnose, treat and be proactive in your health care needs. This means the service will use the information you have provided in the following ways:

- Administrative purposes in the running of the University student health service
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements
- Disclosure to others involved in your health care, including treating doctors and specialists outside this medical practice. This may occur through referral to other doctors for medical tests and in the reports or results returned to us following the referrals.

I have read the information above and understand the reasons why my information must be collected. I am also aware that this practice has a privacy policy on handling patient information.

I understand that I am not obliged to provide any information requested of me, but that my failure to do so might compromise the quality of health care and treatment given to me.

I am aware of my right to access the information collected about me, except in some circumstances where access might legitimately be withheld. I understand I will be given an explanation in these circumstances.

I understand that if my information is to be used for any other purpose other than set out above, my further consent will be obtained.

I consent to the handling of my information by the University student health service for the purposes set out above, subject to any limitations on access or disclosure that I notify this practice of.

I agree to receive relevant health recalls and appointment reminders via either SMS text messaging, e-mail or mail. I can identify the genuine source of the message and can opt out of receiving such messages in the future by notifying the Student Health Services.

Signature.....

Date.....

Name.....(Please print)

Witness.....