FEH090060

easternhealth

Community Health Informed Consent

UR Number: _____

Surname: _____

Given Name: _____

Date of Birth: _____/_____/_____ Sex: M / F

Affix Hospital ID Label If Available

'We value your personal experience and expressed needs and will, always work with you in developing and negotiating treatment plans. After all YOU are the expert on your life.'

The services I will be receiving have been explained to me in language that I understand, and I agree to actively participate in setting and working towards my health goals.

By becoming a client of Eastern Health - Community Health
I/we understand:

- If I have any concerns about a change in my condition that I am being treated for, I understand that I can talk to my treating clinician.
- Community Health services are not suitable for all health conditions and I may be referred to other services that are more beneficial for my needs.
- Participation in treatment is voluntary.
- Confidentiality is essential to a positive experience and will be maintained unless my safety or that of any other person is at risk. If appropriate, further options would then be discussed and considered with me.
- Details of my immediate care will not be discussed beyond Community Health without my verbal or written consent unless they are required for providing urgent medical treatment.
- Electronic files are used throughout Eastern Health to ensure relevant information is available any time I present to an Eastern Health treatment service. These files are managed securely and only accessed by Eastern Health staff and only as required.
- All services will be discussed with me and agreed upon prior to commencement and regularly reviewed to ensure that my needs are being met.
- Eastern Health is an inclusive and respectful health service.

Eastern Health encourages feedback about your experience to assist in the review and improvement of services. Feedback can take the form of a complaint, comment/suggestion or compliment.

If you have any concerns please contact Community Health on 1300 130 381

MEDICAL Assistance
Should you experience a change in your medical condition while at home, please contact your local GP for advice in the first instance.
In the event of a medical emergency, dial 000 or attend your closest hospital emergency department

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I am aware the following information and brochures are available:

- Privacy – 'Protecting your Privacy - Information for patients'
- Patient Rights –'Australian Charter of Health Care Rights'
- Feedback and complaints – 'Your feedback is important. We are listening.'
- Any fees for the services that I am receiving

I and/or my carer agree to.

- Attend my appointments or provide notice that I am unable to attend (at least 48 hours)
- Provide a safe, aggression free environment by respecting all staff
- Be respectful of other people attending the service.
- For home visiting services:
  - Being available at the agreed appointment time
  - Provide a safe work environment for visiting health care workers (Clinicians will call to check on safety requirements prior to visiting)
  - Provide a smoke-free, alcohol-free and recreational drug-free environment during visits

I understand that Community Health services may be withdrawn where there is a risk to me, my carer or Community Health staff. The reasons for withdrawal of services will be fully explained and services will be restored when any identified issues are appropriately addressed.

I may request a review at any time through the complaint process.

Cancellations: If I need to cancel or reschedule an appointment I will attempt to provide at least 48 hours' notice to enable reallocation of this appointment time. If my clinician is unable to meet with me for the scheduled appointment I will be contacted to reschedule the appointment.

Complaints:
If you are dissatisfied with the service you receive you have the right to lodge a complaint either verbally to any staff member (or their manager) or in writing to the Centre for Patient Experience (PO Box 5177, Wantirna South. 3152). Via Email: feedback@easternhealth.org.au.

Signature of Client: _____

Signature of guardian/carer: _____ Name: _____OR
(where appropriate)

Verbal consent received ☐ by: _____
(signature, name and designation)

Signature of Witness: _____ Name: _____

Copy provided to client/carer : Yes ☐ No ☐ Offered and declined ☐ Date: …./…./……

Signature:	Name (please print):	Designation:	Date:

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