Metro North Hospital and Health Service

Aged Care Assessment Team
CONSENT FORM

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F

Consent is required for the Collection (through Assessment) and Release of Information by the Metro North Hospital & Health Service Aged Care Assessment Teams

To provide a comprehensive assessment for you, we request your consent to obtain *personal, medical and social information* from you. We also request your consent to obtain information about you from other *health professionals, service agencies, your family and your doctor.* The information we gather will be kept confidential and will only be used to assist you to receive the appropriate level of care and support.

To enable us to assist you to receive the appropriate level of care, we request your consent to the sharing of *relevant personal, medical and social information to service agencies that will be assisting you, your family and your doctor.* The Aged Care Assessment Team is also required to provide non identifying data from your file to the Department of Health & Ageing for statistical purposes.

You may also require assistance with care coordination to ensure that you have appropriate access to services and support. The Aged Care Assessment Team may contact you, your family or carer to ensure that your current care needs are being met, to provide advice about appropriate services, and to assist you to access services to meet your needs.

You are able *to exclude people or agencies* from this consent. Please nominate them in the space provided. This consent remains current for the period of time that your *Aged Care Application and Approval* is valid. You are, however, able to withdraw your consent for the sharing of information at any time by contacting the Aged Care Assessment Team.

I, ____ have read the information contained in this form and give consent for the Aged Care Assessment Team to consult with relevant parties involved in my care / the care of:

____ my ____

(Name) *(Relationship)*

for whom I am the carer / legal guardian *(delete as required)*.
I also consent to non-identifying information from my / his / her file to be used for data collection and export to the Department of Health and Ageing.

I wish / do not wish to exclude certain people / agencies from this Consent.
Excluded people / agencies are listed below:

____ ____

____ ____

____ ____

Signed _______________________________________ Date: __________/__________/__________

I, ____ *(staff member)* have explained this Consent Form.

Signed _______________________________________ Date: __________/__________/__________

CONSENT WITHDRAWN

Date: __________/__________/__________ By Whom: ____

Reason ____

Name of ACAT staff member___________________________ Signature: _______________________________

DO NOT WRITE IN THIS BINDING MARGIN

ACAT CONSENT FORM

Version 1 October 2012

SASD01.005