School Health Checks

Carbal Medical Services

Dear Parent/Guardian,

Carbal Medical Services are being proactive and offering health checks and follow up services to Aboriginal & Torres Strait Islander students. We understand this is a busy time of year and to assist families to look after their health, we will be visiting your child's School to provide comprehensive health assessments. The Carbal team will be available to provide a 715 health check and 81300 follow up services/consultations with an Aboriginal Health Worker. To participate, the below consent form and details must be completed.

THIS IS A BULK BILL MEDICARE SERVICE.

To sign up for a health assessment/follow up services:

1) Complete this form
2) Return the form to school **by** _____

About the Health Assessment & Follow Up Consultations

A Carbal Nurse and/or Aboriginal Health Worker will talk to the student and perform comprehensive health assessments (blood pressure, pulse, weight, height, eye check, ear check, discussion on healthy lifestyle choices). A doctor from Carbal will meet with each student and review the assessment results and provide any advice and follow up required.
Follow up services will be provided by an Aboriginal Health Worker to provide additional information, heath education and awareness relevant to your child at various times though out the year. These services will be provided at the school during school hours and will not require additional consent.

A summary of the health assessment will be provided to each student/parent.

**A 715 Health Check should be undertaken by your regular doctor. If Carbal is not your regular doctor and you would like to access this service, continue to complete the details below.*

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DETAILS				
Student Name:		Date of Birth:		
Parent's Name:		Contact Phone Number:		
Address:				
Medicare Number:		Line Number:		
Has your child had a health check in the last 9 months:		☐ Not sure	☐ Yes	☐ No

PARENTAL CONSENT

I consent for my child, *(insert name)*..... to have a 715 Health Check & 81300 follow up services by Carbal Medical Services and acknowledge that Carbal will claim directly for these services from Medicare Australia.
I give consent for Carbal Medical Services to release relevant information about my child to the school for the purpose of educational support.

Parent Signature		Date	

ADDITIONAL INFORMATION

FAMILY HISTORY;		ANY CURRENT CHILD CONCERNS;	
☐ Diabetes	☐ Cancer	☐ Diabetes	☐ Hearing
☐ Asthma	Other:	☐ Asthma	☐ Vision
☐ Mental Health		☐ Obesity	Other:
☐ Heart Disease		☐ Mental Health	

Patient Information

Carbal Medical Services

We are committed to providing our patients with the best care.

To do this, it is essential that your personal information is up to date and accurate.

PERSONALINFORMATION					
Title: Mr Master Mrs Ms Miss			**First Name**		
Surname:			**Middle name:**		
			Known as:		
D.O.B:			**Sex:** Male / Female		
Medicare #:			**Ref #** next to your name:	**Expiry:**	
Concession #:			**Expiry:**		
Concession: Health Care Card		Pensioner Concession Card		DVA	
Address:					
Postal (If different from above):					
Phone (H):		**Phone (W):**			
Phone (M):					
Email:					
Marital status (Please circle)					
Single	Married	Widowed	Divorced	Defacto	Separated
Occupation:					
Country of Birth:					
Aboriginal or Torres Strait Islander: Yes / No / Both		**Other:**			
Do you have a Carer ? Yes / No **If yes, are the details the same as NOK?** Yes / No If no please complete the **Carers details form** (please ask reception for this form)					

NEXT OF KIN				
Name:		**Phone:**		
Address:				
Relationship (Please circle)				
Spouse / Partner	Parent	Child	Carer	Other: _____
EMERGENCY CONTACT				
☐ **Same as NEXT OF KIN**				
Name:				
Phone:				
Relationship (Please circle)				
Spouse / Partner	Parent	Child	Carer	Other: _____

Patient Consent

Carbal Medical Services requires your consent to collect personal information about you.

Please read this consent form carefully and sign where indicated below.

Carbal Medical Services collects such information for the primary purpose of providing quality health care. We require you to provide us with your personal details and a full medical history to allow us to properly assess, diagnose, treat and advise on all your health care needs.

I give my consent:

- For my personal health information to be used for administrative purposes to assist in the running of Carbal Medical Services, this will include disclosure to others involved in my healthcare, including care coordination such as treating Doctors, Aboriginal Health Workers, Allied Health Professionals and Specialists within and outside this Medical Practice. This may occur through referral or care coordination to other Doctors, for medical tests and in the reports or results returned to my doctor following referrals
- For disclosure for research, reporting and quality assurance activities to improve individual, community health care and practice management. This may occur when the practice incorporates patient health records into de-identified patient information to transfer to a third party, normally used for quality improvement projects. De-identified patient information cannot be traced back to the individual.
- For my personal health records to be used for identifiable patient health information. This may occur when the Practice participates in research activities on behalf of a university as part of professional development activities to be collected. Identifiable patient information can possibly be traced back to the individual. This will only occur once individual consent has been obtained.
- To be part of the Practice's recall & reminder systems including National, State and Territory recall and reminders, correspondence via electronic communications which includes SMS reminders.

I understand by consenting to the above that the practice is authorised on my behalf to use my relevant personal health information and I am free to withdraw my consent at any one time by written notification. If you do not agree with any of the above statements, please speak to staff.

CONSENT	
Print Name of Patient:	
Signature of Patient (*over 16*):	
Name & Signature of Parent/Guardian *(if under 16)*	
Date:	

NON-ENGLISH SPEAKING PATIENTS ONLY

I_____translated the above information to_____and they have signed above.
(NAME) *(NAME OF PATIENT)*