PATIENT INTAKE AND CONSENT FORM

CmyNP Pty Ltd

Complete before or at your first appointment

Please complete all sections of this form. It gives us the information we need to care for you safely and tells you how we will use your health information. If you have any questions, please ask before you sign.

PART A - YOUR DETAILS

Full legal name	
Preferred name	
Residential address (suburb, state, postcode)	
Phone number	
Email address	
Gender (optional)	
Date of birth	
Medicare number	
Individual Healthcare Identifier (IHI) - if known	
Emergency contact name	
Emergency contact phone	

PART B - YOUR GP AND OTHER TREATING PRACTITIONERS

This helps us coordinate your care safely. We will only contact your GP or other practitioners with your consent (see Part D).

GP name and practice	
GP phone/fax	
Any other treating practitioners (e.g. mental health, specialist)	
Contact details	

PART C - OPIOID TREATMENT SERVICES (COMPLETE IF APPLICABLE)

Complete this section if you are seeking opioid treatment services (OST) from CmyNP. If you are not receiving OST, you can leave this section blank.

Current or previous OST medicines (if any)	
Previous prescriber / clinic (if any)	
Preferred pharmacy / dosing point	
State where you will be dosed (NSW /QLD/ both)	

Are you currently enrolled in an OTP with another prescriber?

☐ Yes - I am currently enrolled with another OTP prescriber and will arrange a transfer.

☐ No - I have not previously been enrolled in an OTP.

☐ I was previously enrolled but am no longer active.

PART D - YOUR CONSENTS

Please read each statement and tick the box to confirm your consent. If you do not understand something, please ask us before you sign.

1. COLLECTION AND USE OF HEALTH INFORMATION

☐ I understand that CmyNP needs to collect my personal and health information to provide clinical care. I consent to CmyNP collecting, holding, using, and sharing my information as described in the CmyNP Privacy Policy, which I have read (or which has been explained to me).

☐ I consent to CmyNP collecting and using my personal and health information to provide me with clinical care and to administer the practice.

2. REAL-TIME PRESCRIPTION MONITORING (SAFESCRIPT NSW AND QSCRIPT)

This consent is required for all patients receiving opioid treatment medicines. It cannot be opted out of - it is a legal condition of receiving OST prescriptions.

☐ I understand that CmyNP is required by law to check SafeScript NSW (for NSW) and QScript (for QLD) before prescribing monitored medicines. I understand that my prescription information will be recorded in these systems and may be seen by other authorised health practitioners involved in my care.

☐ I acknowledge that my prescription information will be shared with SafeScript NSW and/or QScript as required by law, and that other authorised health practitioners may access this information.

3. NOMINATED PHARMACY AND DOSING ARRANGEMENTS

☐ I understand that my prescription will nominate a specific pharmacy or dosing point. I agree to attend my Nominated Pharmacy as required by my prescription and to comply with supervised dosing conditions. I understand that takeaway doses are a privilege, not a right, and are subject to my prescriber's assessment.

☐ I consent to CmyNP sharing my prescription and dosing information with my Nominated Pharmacy.

4. COORDINATION WITH MY TREATING TEAM

☐ I understand that CmyNP may need to share information about my treatment with other health practitioners involved in my care. I can tell CmyNP if there is a specific person I do not want my information shared with.

☐ I consent to CmyNP sharing relevant clinical information with my GP and other treating health practitioners on a need-to-know basis for the purpose of my care.

☐ I do NOT consent to CmyNP sharing my information with my GP or other practitioners. (Please note: this may limit our ability to coordinate your care safely.)

Is there any specific person or organisation you do NOT want your information shared with?

5. SOCIAL FUTURES AND NSW MINISTRY OF HEALTH (COMPLETE IF APPLICABLE)

☐ If I am receiving services through the arrangement between CmyNP and Social Futures (funded by the NSW Ministry of Health), I understand that certain information about my treatment may be shared with Social Futures and the NSW Ministry of Health as required under that arrangement.

☐ I consent to CmyNP sharing relevant information with Social Futures and the NSW Ministry of Health as required under the funded service arrangement.

☐ Does not apply to me

6. EMERGENCY CONTACT AUTHORISATION

☐ I understand that if CmyNP is concerned for my immediate safety during a consultation (including a telehealth consultation), they may contact emergency services at my last known location.

☐ I consent to CmyNP contacting emergency services at my last known location if they have a genuine concern for my immediate safety.

7. **OVERSEAS DATA STORAGE (XERO)**

☐ I understand that CmyNP uses Xero for accounting and that limited financial information (my name and invoice details) may be stored on Xero's servers in the United States. No clinical health information is stored in Xero.

☐ I acknowledge that limited financial data (name and invoice details only) may be stored in Xero's overseas servers.

8. **SERVICE AGREEMENT**

☐ I confirm that I have read and understood the CmyNP Patient Service Agreement and agree to its terms.

PART E - COLLECTION STATEMENT (SUMMARY)

The following is a plain-language summary of how CmyNP handles your information. Our full Privacy Policy is available at www.cmynp.com.au

What we collect	Detail
Identity and contact details	Name, date of birth, address, phone, email, emergency contact
Health information	Medical history, medications, clinical notes, treatment records, test results
OST-specific information	OTP enrolment, medicines prescribed, dosing arrangements, RTPM records
Government identifiers	Medicare number, IHI - used only for clinical and billing purposes
Financial information	Invoice and payment records (stored in Xero - name and invoice details only)
Identity verification	Government photo ID sighted at first consultation
Who we share with	SafeScript NSW / QScript (required by law), your Nominated Pharmacy, your treating healthcare team (with consent), Social Futures and NSW Ministry of Health (where applicable), Medicare, pathology services
Retention	Minimum 7 years (adults) from last consultation. Longer for child patients. See Privacy Policy for details.
Your rights	Access, correct, and (in limited circumstances) request deletion of your information. Complaints to us or the OAIC (www.oaic.gov.au).

PART F - DECLARATION AND SIGNATURE

By signing below, I confirm that:

(a) I have read this form (or it has been read to and explained to me) and I understand its contents; the information I have provided is accurate and complete to the best of my knowledge;

(b) I have ticked the consent boxes above that apply to me; and

(c) I understand that I can withdraw any consent or update my preferences at any time by contacting CmyNP.

Patient signature: **Signed on behalf of patient (if applicable):**

Signature Signature

Name

Name

Date

Date

For CmyNP Staff Use Only	
Form received by:	
Date received:	
Entered in Halaxy:	