Consent to share information for referral and care

For health professionals, pharmacies, clinics and NGOs referring a patient to CmyNP.
Complete it with the patient and upload it securely with the referral.

CMYNP PTY LTD • Shari Edwards, Endorsed Nurse Practitioner • AHPRA NMW0001666654

YOUR CHOICE, YOUR CONTROL

This consent is voluntary. You choose who CmyNP may talk with and what may be shared, and you can limit, change or withdraw it at any time. Saying no will not stop you from receiving care from CmyNP.

01 PATIENT DETAILS

FULL LEGAL NAME

PREFERRED NAME (OPTIONAL)

DATE OF BIRTH (DD/MM/YYYY)

PHONE

EMAIL

ADDRESS

MEDICARE NUMBER (OPTIONAL)

CARD REFERENCE / IRN (OPTIONAL)

CARD EXPIRY MM/YY (OPTIONAL)

02 REFERRER DETAILS

REFERRER NAME

CLINIC / ORGANISATION NAME

ROLE / POSITION

WORK PHONE

SECURE WORK EMAIL

REASON FOR REFERRAL / CARE REQUESTED

03 WHO CMYNP MAY EXCHANGE INFORMATION WITH

- ☐ The referring person or service above
- ☐ My nominated pharmacy
- ☐ Pathology or diagnostic imaging service
- ☐ Family member, carer or advocate
- ☐ My GP or medical centre
- ☐ Specialist, hospital or mental health service
- ☐ AOD, NGO, housing or support service
- ☐ Other named person or service

NAMES AND CONTACT DETAILS OF THE PEOPLE OR SERVICES TICKED

DO NOT CONTACT — PEOPLE OR SERVICES I DO NOT WANT CMYNP TO SPEAK WITH

04 WHAT MAY BE SHARED — TICK ONLY WHAT IS NEEDED

- ☐ Identity and contact details
- ☐ Medical history, allergies and current medicines
- ☐ Mental health and wellbeing information
- ☐ Prescribing and pharmacy dispensing information
- ☐ Referral letters and health summaries
- ☐ Pathology and investigation results
- ☐ Alcohol and other drug treatment, including ODT
- ☐ Appointment and care-coordination details

OTHER INFORMATION OR LIMITS (E.G. DO NOT SHARE SEXUAL HEALTH RESULTS)

05 HOW LONG THIS CONSENT LASTS

- ☐ Until this episode of care with CmyNP ends
- ☐ Until this date:
- ☐ For 12 months from the date signed

06 I UNDERSTAND THAT

- CmyNP is a private nurse practitioner service. Referral is my choice and I may choose a different provider.
- CmyNP will only collect, use and share information reasonably needed for my care, in line with the CmyNP Privacy Policy.
- I can change or withdraw this consent at any time by contacting CmyNP. Withdrawal does not affect information already shared.
- CmyNP may still share information without consent where required or authorised by law, such as a serious risk to safety.
- Telehealth does not replace a physical examination; I may be asked to see a clinician in person if needed.

☐ I have read (or had read to me) and understood this form, and I agree to the choices above.

07 SIGNATURES

PATIENT SIGNATURE | PRINTED NAME | DATE

If signed by a guardian or substitute decision-maker:

NAME | RELATIONSHIP / AUTHORITY | SIGNATURE

REFERRER / WITNESS NAME | SIGNATURE | DATE

☐ An interpreter was used. Language:

SENDING THIS FORM
Upload the signed form with the referral at cmynp.com.au/refer. Please do not send it by unsecured email.