Eye and Ear Surgical Support (EESS) Program 2024-2025

Patient Information and Consent Form

Please complete all relevant sections and email completed form to vicoutreach@rwav.com.au. **Please note that this form will be deemed ineligible if any required fields are left incomplete.**

Referrer Details *(Key Contact)*	
Name of Referrer:	
Organization:	
Phone:	
Email:	

Patient Details *(any collated data under EESS will be de-identified)*		
Patient Full Name:		
Date of Birth:	Click or tap to enter a date.	
Home Address:		
MMM Location	Choose an item.	
Is the patient of Aboriginal and/or Torres Strait Islander origin?	☐Yes, Aboriginal ☐No, Do Not Identify	☐Yes, both Aboriginal and Torres Strait Islander ☐Yes, Torres Strait Islander
Has the patient/parent/carer signed the consent form? Please see below Yes ☐No ☐		

Patient Consent for EESS Program Support

I, _____ (Patient/Parent/Carer Name),
hereby give my consent to provide Rural Workforce Agency Victoria (RWAV) with my name and appointment information to access Eye and Ear Surgical Support (EESS) Program.

I understand that the Patient information provided in the within form will be used to assess eligibility for funding and/or support from Outreach EESS program and for RWAV to undertake their duties in the administration of Outreach EESS, including the Australian Government Department of Health, the Victorian Outreach Advisory Forum and other individuals, agencies or organisations (e.g. local health providers) as required by law or as deemed necessary by RWAV to fulfil its obligations in the administration of Outreach EESS program.

I further understand that this information will be kept confidential, in line with Rural Workforce Agency Victoria's Privacy Policy in accordance with The Privacy Act 1988, which governs collection, use, disclosure and security of personal information.

By completing this form and signing below, I give permission for RWAV to use the information provided in accordance with the confidentiality and privacy procedures as are set out in the policy statement that can be obtained from RWAV.

PLEASE NOTE If you have any concerns in respect of this form, please email vicoutreach@rwav.com.au prior to signing the form.

Name:

Date:

Signed by Patient, Parent or Carer:

Please see attachment on original form

Patient Story
Short description on lifestyle limitations and why the surgery is needed: Examples: Eyesight- Reducing the patient's ability to drive impacting their independence to visit family/friends. Hearing: Child having reoccurring Otitis Media impacting their ability to learn new activities as they cannot hear instructions

Procedure Details	
Eye Procedure	☐ Cataract -Please specify ☐Left eye ☐Right eye ☐Both eyes ☐Other:
Ear Procedure	☐Adenoidectomy (+/- tonsillectomy) ☐Myringoplasty/tympanoplasty ☐Myringotomy ☐Grommets (*Insertion of pressure equalizing tubes)* Please specify☐ Left ear ☐Right ear ☐Both ears ☐ Other:
	If ear-related, is surgery required as a result of Otitis Media? ☐Yes ☐ No

Date the patient was referred for surgery by Specialist*:	Click or tap to enter a date.
Is the patient currently on a public waitlist?	☐Yes, hospital: ☐No
Please tick whether this application is for Private or Public procedure?	☐ Private ☐Public

Stakeholder Details			
Anaesthetist name:			
Practice/Clinic Name			
Primary Practice Address:			
Key Contact:			
Phone Number:		**Email:**	

Surgeon name:			
Practice/Clinic Name:			
Practice/Clinic Address:			
Key Contact:			
Phone Number:		**Email:**	

Hospital/Clinic:			
Practice/Clinic Name:			
Practice/Clinic Address:			
Key Contact (account/ finance):			
Phone Number:		**Email:**	

Pre-Consultation Details		
Will the patient require pre – consultation support? ☐Yes ☐No		
Pre-consultation details:	**Date of pre-consultation:**	Click or tap to enter a date.
	Location of pre-consultation:	
	Will the patient be accompanied by a parent or carer?	☐Yes ☐No

	Transport to pre-consultation:	☐ACCO Transport Driver ☐Hire car ☐Taxi ☐Commercial Flight ☐Client/Carer's own car ☐Other _____
	Will the patient and/or carer require meal allowance?	☐ Yes ☐No
	Accommodation required?	☐Yes, Length of stay_____ (days) ☐No

Surgery Details		
Will the patient require surgery support? ☐ Yes ☐ No		
Surgery Details:	**Surgery date:**	Click or tap to enter a date.
	Surgery Fees ***Please provide individual quotes.***	☐ Anesthetists Fees: ☐Hospital Fees: ☐Surgeon Fees:
	Will the patient be accompanied by a parent or carer?	☐Yes ☐No
	Accommodation required?	☐Yes, Length of stay_____ (days) ☐No
	Transport:	☐ACCO Transport Driver ☐ Hire car ☐Taxi ☐Commercial Flight ☐Client/Carer's own car ☐Other _____
	Will the patient and/or carer require meal allowance?	☐Yes ☐No

Post-Consultation Details		
Will the patient require post-consultation support? ☐ Yes ☐ No		
Post-consultation details:	**Date of post-consultation:**	Click or tap to enter a date.
	Location of post-consultation:	
	Will the patient be accompanied by a parent or carer?	☐Yes ☐No
	Transport to post-consultation:	☐ACCO Transport Driver ☐Hire car

		☐Taxi ☐Commercial Flight ☐ Client/Carer's own car ☐ Other _____
	Will the patient and/or carer require meal allowance?	☐Yes ☐ No
	Accommodation required?	☐Yes, Length of stay_____ (Days) ☐No

Rural Workforce Agency Victoria Use Only	
Total Estimated Cost for Patient Support *(Please list applicable support for travel, meal, accommodation, and surgery)*	**Pre-consultation costs:** **Surgery costs:** **Travel:** Total KM = **Accommodation:** **Meals:** Breakfast Lunch Dinner Total: **Post-consultation costs:**
Patient Surgery Support Approval by Rural Workforce Agency Victoria under the Eye and Ear Surgical Support (EESS) Program **EESS Patient number:** Assessed by: Date: Approved by: Date:	


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