Telehealth Consent Form

Client Details

Name:

Address:

Date of Birth:

Nominated email address:

Referring Doctor (if appropriate):

Guardian Details

Name:

Address:

Date of Birth:

Consent statements

- I declare that I am the legal guardian to the client and that the information provided on this form is true and accurate at the time of signing and that my identity is that stated on this form.
- I consent to the passing of information in relation to the client's treatment to be sent to the nominated email address.
- I give permission for the therapist to contact the referring doctor in reference to their treatment.
- I give permission for the therapist to contact further specified health professionals (e.g. General Practitioners, Orthopaedic Specialists) in reference to their treatment.
- I understand that Telehealth treatment (treatment via email, telephone or video conference) has limitations (e.g. therapist being unable to conduct a physical examination) and that the therapist will make every effort to still provide a high standard of care.
- Should the therapist feel that a physical examination is required in order to ensure best treatment, I consent to the therapist referring the client onwards for a physical examination and/or other relevant testing.

Signed: ________________________(Guardian)

Date: __________________________