**Consent for Participation in the Pain Management Programme**

I,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_consent

(Print name of client) (Address)

to participate in the Pain Management Programme.

And give my consent for and acknowledge the following (please tick each box):

* The collection of my personal (name, address and contact details) information for the purpose of participation in the Pain Management Programme.
* My medical information will be collected for the purpose of monitoring my progress during the programme. This may include; details of my pain, abilities to function, physical measurements and other data.
* My medical information will be referred to in correspondence with my nominated health providers, for example my GP.
* I give permission for my nominated health care providers to forward information pertaining to my participation in the Community Pain Programme to the program coordinator, for the purposes of referral and evaluation.
* I understand that any information collected for the purpose of evaluating the Pain Management Programme will be de-identified and my name will not be linked with the information.
* I understand that at any time during the programme, I may withdraw or modify this consent by contacting the service at the number listed on the service information provided to me.

**Media Consent**

* I **consent** to the use of photos/footage/interviews of me to be used for education and evaluation materials to promote this Pain Programme.
* I **do not consent** to any photos/footage/ or interviews being released.

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I have explained the request for consent to the above named participant and have answered their questions.

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Designation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Published Oct 2017. ACI/D23/889 © State of NSW (Agency for Clinical Innovation)