[Insert WoSSP partner logos]

# T4.5.a Whole-of System Student Clinical Placement (WoSSP) ProgramPatient participation consent form

*NOTE: Students must submit this consent form to the WoSSP clinical educator; it is not to be handed in with the completed report. This form must be printed double-sided on one sheet to ensure that student and patient signatures are kept together.*

## About the WoSSP program

[Insert health service name] is working with [insert health education provider partners] to provide a Whole-of-System Clinical Placement (WoSSP) for medical, nursing and allied health students in the [InsertLGA] local government area. Under the supervision of experienced clinical educators, medical, nursing and allied health students work alongside patients in the community to learn about their healthcare journeys. If you are happy to participate in the WoSSP program, please sign and date this form to indicate your consent.

## Patient consent

I have had the WoSSP patient journey study explained to me. I understand that agreeing to take part means that I am willing to allow students involved in the WoSSP program to learn about my journey through the local health system by:

* accompanying me to a scheduled GP consultation
* conducting a home visit
* discussing my medical condition/s with a small team of two to three health professional students
* discussing my healthcare journey (with no identifying information) with other health student participants in the patient journey study days at the [insert health service]
* presenting and writing up the study with the information from our meetings (with no identifying information)

Please tick each statement below to indicate you understand and agree:

❑ I understand that my participation in the WoSSP program is voluntary.

❑ I agree to be interviewed by small team of two to three students.

❑ I understand that any data that students extract from the interview for use in reports and the patient journey study days will not, under any circumstances, contain names or identifying characteristics.

❑ I understand that any information I provide is confidential. No information that could lead to me being identified will be disclosed in any reports on the case study or to any other party.

❑ I understand that [insert health service] is aware of this student and the study.

❑ I understand students will seek permission to visit a health service before accompanying me to my appointment.

|  |  |  |  |
| --- | --- | --- | --- |
| **Patient name** |  |  |  |
| **Patient signature** |  | **Date** |  |

## Student team members

|  |  |  |  |
| --- | --- | --- | --- |
| **Student name** |  | **Course** |  |
| **Student signature** |  | **Date** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Student name** |  | **Course** |  |
| **Student signature** |  | **Date** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Student name** |  | **Course** |  |
| **Student signature** |  | **Date** |  |