# Observed Consultation Patient Consent Form

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| **Date:** | **Practice Name:** |

Dear Patient

Today Dr (candidate) has Dr (observer) observing him/her.

This is a peer review and contributes to quality assurance and ongoing professional development according to ACRRM guidelines.

* Dr (observer) will be sitting in the same room and observing the consultation.
* Dr (observer) will be observing the consultation via video link.

The observing doctor will not contribute to the consultation but may take notes for clinical performance feedback purposes. Your confidentiality is guaranteed.

If you consent to the observer’s presence in your consultation, you can withdraw consent at any time and ask the observing doctor to leave the room.

Thank you for considering your participation in professional development and the delivery of quality care. Yours sincerely,

Dr (candidate)

**Patient Consent**

I have read and understood the information about observed consultations.

* I do consent to Dr (observer) observing my consultation today
* I do not consent to Dr (observer) observing my consultation today.

Name:

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

Date: