



Australian College of
Rural and Remote Medicine

ABN 12 078 081 848

Vocational Training
Assessment

ACRRM FORMATIVE MINICEX 2010 PATIENT CONSENT FORM

Consulting Doctor:
Observing Doctor:

Dear Patient

Today I will be participating in an educational assessment known as the Mini Clinical Evaluation Exercise (MiniCEX) assessment, which is conducted by the Australian College of Rural and Remote Medicine. The observing doctor in today's consultation will provide information that will help me, your doctor move forward in attaining higher medical qualifications and is an important part of my ongoing education and training. Your participation as a patient will greatly assist in this process by providing an opportunity for me to demonstrate my medical skills.

The consultation will be unchanged except that a senior doctor will be sitting in with us in the same room and observing this consultation. The observing doctor will not contribute to the consultation. Although the observing doctor may make notes during the consultation, these notes will not include any identifying features so that you will remain an anonymous participant.

If you have any further questions about this process you are welcome to discuss them with me or if you wish with the coordinator of this program, Rachel Holmes, of the Australian College of Rural and Remote Medicine (contact details at the bottom of this form).

If you decide to participate, you are welcome to withdraw your consent at any time and ask the observing doctor to leave the room. Any decision you make about whether to participate or not will have absolutely no bearing on your medical care by me or anyone else.

Thank you for considering participating in this important event.

Yours faithfully

Dr

Patient Consent

I agree to participate and understand the issues that have been raised in this document. I understand that I can ask the observing doctor to leave at any time and any decision I make regarding this will have absolutely no bearing on my current or future health care.

Name (please print): _____

Signature: _____ Date: _____

Two copies are required. One copy is for the patient, the second copy is to be retained on file

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