THE MIND FACULTY
Psychiatry & Psychology Medical Center

CONSENT FOR TELEMEDICINE SERVICE

NAME OF PATIENT :

MYKAD / PASSPORT NO. :

1. I,_____, hereby consent and agree to participate in this Telemedicine Service (as defined in Telemedicine Act 1997), for myself OR in the case of the above mentioned patient who is a child less than 18 years of age and / or a patient who is incapable or lacks the capacity to manage him / herself.

   Please provide your relationship with patient (i.e. Parent / Guardian / Next of kin):

   _____

2. I will be consulting a Physician / Healthcare Practitioner from The Mind faculty Centre.

3. I, _____, also understand that:
   - Telemedicine Service involves delivery of health care services by Physician / Healthcare Practitioner using information and communication technologies (ICT - electronic communications) enabling the Physician /Healthcare Practitioner at a different location to facilitate exchange of information with clients including but not limited to sharing of individual patient's medical information, prior health history, present complaints for diagnosis, treatment, prevention of disease and injuries and improving patient care.
   - The Telemedicine Service is done through a two-way video link-up whereby the Physician /Healthcare Practitioner can see my / patient's image on the screen and hear my / patient's voice but in any event does not equate in terms of accurate diagnoses and treatment as compared to a traditional face-to-face consultation.
   - I, _____, have the opportunity to ask questions about the information presented on this document during the Telemedicine Service. However, I, _____, may refuse or withhold or decline this Telemedicine Service at any time without affecting my / patient's right to future care or treatment, or risking the loss or withdrawal of any program benefits to which I / patient would otherwise be entitled.
   - Non-medical personnel and / or trained staff and / or employee may be present to assist in operating video conferencing and I, _____ , have been fully informed on their identity (including name and designation) and presence.
   - I, _____, reserve the right to exclude anyone during this Telemedicine Service.
   - Following the Telemedicine Service, the Physician / Healthcare Practitioner may recommend a visit to the nearest hospital for further evaluation and physical examination.
   - I/patient may need to visit an appropriate Physician / Healthcare Practitioner or trained staff or employee in-person immediately after the Telemedicine Service if an urgent need arises OR in the situation where such Telemedicine Service is not available and I, _____, have been accordingly informed. I / patient am aware that Telemedicine / online therapy is not suitable if I / patient is experiencing suicidal thoughts and / or psychotic episodes.

- In the event that I, _____, refuse or withhold or decline this Telemedicine Service at any point of time, I, _____, understand that I /patient may have to travel to see a Physician / Healthcare Practitioner in-person.
- There will be visual and audio recordings of the consultation and will be part of my / patient's confidential medical records that can be used to assist in the diagnosis, treatment and outcome of my /patient's condition.
- The Physician / Healthcare Practitioner will be making visual and audio recording during this Telemedicine Service.
- I,_____, understand that I will not have access to these recordings.
- I, _____, have been advised that there are **potential risks, consequences** to this Telemedicine Service, including but not limited to interruptions or disconnection of audio / visual links, unauthorized access, technical difficulties, image that is not clear enough to meet the needs of the consultation, and in rare cases lack of access to complete medical records which may result in adverse drug interactions or allergic reaction.
- The Physician / Healthcare Practitioner or I, _____, can discontinue this Telemedicine Service if it is felt that the video conferencing connections are not adequate for the situation.
- This Telemedicine Service shall be **subject to payment of certain charges** which shall be determined by the Physician / Healthcare Practitioner and / or Centre.
- However, for couple and family therapy, the Physician / Healthcare Practitioner will practice a **"No Secrets"** policy whereby the Physician / Healthcare Practitioner will not keep any private information or "secrets" from either partner or family members in the therapy to maintain trust in the therapeutic relationship.
- This Telemedicine Service will be subject to the Laws of Malaysia.

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I, _____, UNDERSTAND AND CERTIFY THAT:-

a) **I,_____HAVE READ AND UNDERSTOOD THIS CONSENT/DOCUMENT TOGETHER WITH ITS CONTENTS INCLUDING THE RISKS, CONSEQUENCES AND BENEFITS OF THE TELEMEDICINE SERVICE BEFORE SIGNING.**

b) **IF NEEDED, I,_____, CAN ASK THE PHYSICIAN / HEALTHCARE PRACTITIONER TO EXPLAIN THE INFORMATION PRESENTED ON THIS DOCUMENT DURING THE TELEMEDICINE SERVICE.**

c) **I,_____, SHALL BE RESPONSIBLE FOR ALL THE INFORMATION DISCLOSED IN THIS CONSENT/DOCUMENT AND IN THE EVENT THERE IS FALSE OR MISLEADINGG INFORMATION BEING PROVIDED AND/OR INFORMATION HAS BEEN WITHHELD, I,_____, AGREE TO FULLY IMDENIFY THE PHYSICIAN AND / OR HEALTHCARE PRACTITIONER AND/OR CLINIC;**

d) **FURTHER, I, _____, VOLUNTARILY AGREE TO PARTICIPATE IN THE TELEMEDICINE SERVICE FOR THE SERVICE(S) DESCRIBED ABOVE;**

e) **I,_____, UNDERSTAND THE LIMITATIONS IN THE PROVISIONS OF TELEMEDICINE SERVICE AND I,_____, FURTHER CERTIFY THAT I,_____DO NOT HAVE ANY COGNITIVE DISORDERS, INTOXICATION AND I, _____, FULLY UNDERSTAND THE LANGUAGE BEING USED IN THE PROVISION OF THE SERVICES;**

f) **THE TELEMEDICINE SERVICE ARE BEING PROVIDED IN GOOD FAITH WITH THE VIEW OF DISPENSING WITH PHYSICAL CONSULTATION WHERE APPROPRIATE/NECESSARY.**

I AGREE THAT IF I MAKE ANY RECORDING OF MY CONSULTATION, THE RECORDING WILL NOT BE SHARED IN ANY SOCIAL MEDIA PLATFORM.

Patient's/Parent/Guardian/Next of Kin Name & Signature	**Date/Time:**
MyKad/Passport No.:	
If other than patient, provide relationship to patient:	
Physical/Healthcare Practitioner's Name & Signature	**Date/Time:**