NUHS
National University Health System

Consent for Video Conferencing Services by Patients

Instruction: For competent patients above 21 years of age or patients below 21 years who are assessed to have capacity to provide valid consent.

PART 1: TO BE COMPLETED BY PATIENT

1. I, ______________________________________ (Name of patient) ______________________ (NRIC of patient) (the "**Patient**"), hereby consent to enroll into the video conferencing services offered by ____ (Name of NUHS department) at National University Health System Pte Ltd ("**NUHS**"). I confirm that the nature, purpose, benefits, significant limitations, material risks and alternatives of the video conferencing services have been clearly explained to me by ___________________________________ (Name of Healthcare Professional) (the "**Healthcare Professional**").

2. This video conferencing service provided by NUHS and its appointed vendor enable member(s) from the NUHS health care team (defined below) to communicate with me remotely using communication technologies to conduct tele-consultation services.

   I consent to participate in the following types of tele-consultation services. The use of video conferencing with (the "**Service**"):-

   ☐ A physician from NUHS

   ☐ A nurse from NUHS

   ☐ An allied health professional from NUHS

   ☐ Others (please specify) __________________________

   (Collectively, the "**NUHS healthcare team**").

3. As the Service involves the use of communication technologies, I consent to the following:
   (a) The use of my Personal Data (as defined in the Personal Data Protection Act of Singapore) for the Service and for NUHS to contact me regarding this Service.
   (b) All medical information collected during the session will be documented as part of my medical records.
   (c) The use of fax, scanner and/or email to send or receive my health related information (including but not limited to health related information, medical records, test or procedure results, and forms).
   (d) The use of mail and/or courier service to send or receive my health related information and medical records as applicable (any mailing/courier charges will be billed to me, if applicable).
   (e) Any member of the NUHS health care team having access to my medical records and health related information (including my records, information, tests and procedures done/kept outside of NUHS).

(f) Any member of the NUHS health care team assisting in the arrangement of follow-up or consultation medical appointments, allied health services, referral to other medical specialties, and for dietetic, physiotherapy/occupational therapy, psychiatry services if applicable.

4. I understand and **undertake** that I will **NOT** take any photograph or video during any video conferencing session for any reasons whatsoever. I further **acknowledge and agree that in the event any photograph or video is taken of any video conferencing session, NUHS reserves the rights to request and I shall comply promptly to (1) demand for the deletion of such content permanently, (2) remove any of such content from any media platform and/or social media immediately and NUHS reserves the right to take legal action where necessary. In this connection, NUHS will terminate the Service immediately.**

5. I understand and acknowledge the following limitations of the Service:
   (a) The video connection may not work or that it may stop working during the session;
   (b) The video picture or information transmitted may not be clear enough to be made useful for any advice or diagnosis during the video conferencing session;

   In the event that any internet or equipment issues result in the prevention of clear communication or transmission of data, NUHS reserves the right to terminate the Service.

   In the event of a service failure, if the purpose of the video conferencing service is to replace a consultation with my medical practitioner, a face-to-face appointment will be scheduled if any forms of limitations mentioned above were not suitably resolved.

6. NUHS reserves the right to terminate the Service in the event I fail to comply with the scheduled tele-consultation without reason.

7. I can terminate the Service by giving the relevant department in NUHS a written notice of not less than 5 working days. I will remain responsible for any costs and expense accrued prior to the date of the aforementioned notice.

8. As the Service is not an emergency consultation service, in an emergency or in case of any type of urgent medical complaints, I will seek appropriate medical care.

9. I understand and acknowledge that I will be charged for, and shall be responsible for the payment for the Service and its related services, if applicable.

10. I also understand that the charges of the Service and its related services shared with me are merely an estimate and that the actual charges incurred by me may differ depending on the type and extent of the Service provided to me.

______________________________ ______________________________

Signature of Patient | Date

PART 2: FOR OFFICIAL USE

I, ___________________________________ (Name of Healthcare Professional), certify that I have explained the nature, purpose, benefits, significant limitations, material risks and alternatives of the video conferencing services and its related services to the Patient. I have given also the Patient an opportunity to ask questions and clarify any concerns that the Patient may have in relation to the information provided. To the best of my knowledge, the Patient understands the nature, costs, risks and benefits of his/her participation in the Service.

______________________________ ______________________________ ____________________

Signature of Healthcare Professional | Professional Registration Number (if applicable) | Date

By Interpreter

I, ___________________________________ (Name of Interpreter), confirm that I have explained to the Patient the information in this Consent Form, any related documents and related discussion between the Patient and the Healthcare Professional in relation to the video conferencing services in __________________________ (Language/Dialect).

______________________________ ______________________________

Signature of Interpreter | Date

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