APSU CONTACT PERMISSION

***Do you wish to participate in the active surveillance of uncommon high impact conditions of childhood through the APSU?***

** YES I will participate in APSU surveillance and report by email at the end of each month.**

1. Please provide your preferred contact details for APSU correspondence including contact telephone

numbers and email:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hospital / Practice Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

2. My qualifications are: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. What percentage of your patients are <16 years of age? 0-49%  50-100%

4. Does your clinical practice involve acute admissions? Yes  No

5. Which of the following best describes the nature of your practice?

* I am a general paediatrician

 I am a paediatrician with a subspecialty or special interest. Please specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* I am a specialist but not a paediatrician, who sees children <16 years of age. Please specify your specialty:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

** NO I do not wish to participate because:-**

**I do not see patients <16 years of age;**



** I do not work in clinical practice and I do not see patients;**

** Other reasons (please specify):**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**THANK YOU FOR TAKING THE TIME TO COMPLETE THIS FORM**

**PLEASE FAX TO (02) 9845 3082**

**CONFIDENTIALITY**

*Your personal information and any data you provide to the APSU are confidential and will not be used for any other purpose or disclosed to a third party without your permission. If you report a case, your contact details will be forwarded to the appropriate Surveillance Study Investigators for the collection of brief de-identified clinical information about that case. All APSU studies undergo review by a Human Research Ethics Committee prior to commencement. Surveillance study data are stored and managed according to NHMRC National Statement on Ethical Conduct in Human Research.*

*As a contributor to APSU, you may be acknowledged by name in the Annual Report or publications unless you indicate otherwise.*

* **I do not wish to be acknowledged by name in APSU Annual Reports**