UWA – Doctor of Medicine – Volunteer Patient Program Questionnaire

1. Name: ____________________________________________

2. Gender: please tick    Male    Female

3. Date of birth: _______/ _______/ _______
   (day)     (month)     (year)

4. Home Address (Please include post office box if applicable):
   ____________________________________________
   ____________________________________________
   ____________________________________________

5. Home phone number: __________________________________

6. Mobile phone number: __________________________________

7. E-mail address: ________________________________

Please place an X in one box for each statement:

8. Yes  No    I am willing to be contacted to participate as a simulated patient for LEAPS, Clinical Skills practice sessions and Case Enhanced Learning sessions (payment $25.00 per 2 x hr session).
   Payment covers your travel/parking expenses.

   Please note: patients who have attended several in-class sessions may be selected to participate in the assessment sessions.

9. Yes  No    I am willing to be contacted to participate as a simulated patient for clinical skills assessments (exam days) (payment $25.00 per hour). Reserve parking may be available for these sessions.
10. Please indicate below which day(s) and time(s) you **would NOT be available to attend** a two hour session:

<table>
<thead>
<tr>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
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11. Please list your current medical condition(s) if applicable and any previous significant medical procedures you have had, the year of diagnosis / year of procedure, and any signs / symptoms you currently experience. (Only complete if you have a current medical condition or had a significant medical procedure or event.)

<table>
<thead>
<tr>
<th>Medical condition/procedure</th>
<th>Year of diagnosis / procedure</th>
<th>Signs/symptoms</th>
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<tr>
<td>e.g. Asthma</td>
<td>2002</td>
<td>Breathlessness</td>
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12. Please provide any additional information on your medical history that you feel may assist us in scheduling you at an appropriate time that will coincide with the content taught to our medical students.

_____________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________
13. Please feel free to comment on anything not covered in this questionnaire that you feel we should be aware of.

________________________________________________________________________

14. To ensure full disclosure and any conflict of interest kindly please advise if you know personally any medical student currently studying at UWA (full name please).

________________________________________________________________________

15. To ensure full disclosure and any conflict of interest kindly please advise if you know personally any GP/Tutor presently teaching for the Doctor of Medicine program at UWA.

________________________________________________________________________

16. By signing below I acknowledge:

   a) as part of assessment sessions (as a simulated patient) I will not engage in unauthorised communication or collaboration prior to, during and/or after an assessment by any means which seeks to obtain an unfair advantage for any assessment candidate.

   b) I will not engage in conduct which impairs or may impair the reasonable freedom of any assessment candidate pursuing prior to or during their assessment activities.

   c) I agree to the UWA Doctor of Medicine program retaining my personal health information. Your records will only be accessed by authorised UWA staff members for the intended purpose of teaching activities and to comply with the Privacy Act.

Informed Consent
Signature: ___________________________ DATE: ___________________________

Thank you for taking the time to answer these questions.

NOTE: By agreeing to participate as a Simulated Patient in the Doctor of Medicine program you accept that information received during tutorial and examination sessions does not replace medical advice.
Please return the form at your earliest convenience either by emailing the completed document to to mdpatients-fmdhs@uwa.edu.au OR by post using the address details below:

Att: MD Patient Program Administrative Officers
SPARHC Mailbag: M706
The University of Western Australia, Crawley WA 6009