Letter of Consent

Consent to participate in the Coloplast referral for Bowel Dysfunction Evaluation Network

I, hereby consent that my contact details details be used to refer patients wishing to have their current treatment for bowel dysfunction evaluated. Please only use my contact details as specifically outlined below:

Please choose your preferred referral method:

☐ I consent to my contact details being published on the Coloplast Australia and New Zealand Website (www.coloplast.com.au/Bowel-Evaluation) and also to be provided directly to patients as they call through to the Consumer Excellence team.

OR

☐ I consent for myself to be contacted by a Coloplast employee who will provide me with the patient details1 for me to follow up with. I commit to following up with the patient within two business days of receiving their details and will inform the Coloplast employee if this is not possible or the patient cannot be taken on.

1 date of enquiry, full name, address, phone number, email address, best time to contact

If choosing Option 1, please complete the following table with your best contact details to pass on to potential patients, along with area of speciality if this applies.

Contact Details and Area of Specialty

Full Name				
Position / Title				
Area of Specialty	Please tick as areas of speciality as appropriate:			
	Age:	☐ Adult	☐ Paediatric	
	Condition:	☐ SCI	☐ MS	☐ SB
	☐ Other: Please specify: _____			
Organisation				
Address				
Phone Number				
Email Address				
Best day / time to contact				

_____
[Insert Full Name]

_____
[Signiture]

_____
[Date]