**CONSENT FOR TELEHEALTH ISV MEDICAL ASSESSMENT**

Please return the signed consent form to the person who arranged your assessment (CTP insurer or lawyer) as soon as possible. Your telehealth assessment will not proceed unless signed and returned.

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| **This section is to be completed by the assessment referrer**  | **Claim Information** |
| CTP Insurer: |  | Claim number: |  |
| Claims Manager’s name: |  | Contact number: |  |
| Lawyer’s name (if legally represented): |  | Contact number: |  |
| **Assessment Details** |
| AMP name: |  |
| **Claimant Details** |
| Full name: |  |
| Date of birth: |  |
| Address: |  |

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| **This section is to be completed by the injured person**  | The address where your assessment will be held (e.g. your home) |  |
| **Support Person** |
| Name: |  |
| Relationship to you: |  |
| Contact number: |  |

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­\_\_\_\_\_\_\_, have read and understood the information in the ‘Telehealth for Pure Mental Harm Injury Scale Value Medical Assessments’ Information Sheet and I agree to participate in an ISV Medical Assessment via telehealth. I consent to the AMP speaking with my support person and a health professional providing my treatment if required. I consent to the MAIAS Administrator being notified of information relating to my ISV Medical Assessment via telehealth.

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| Your Signature: |  |
| Date: |  |