

Title and full name of practitioner: _____ Location of contact: _____

Date and Time of contact with patient	Patient's full name, date of birth and contact number	Patient consent provided and documented on patient record? (Yes/No) – if no, please state reason	Chaperone's full name	Chaperone's confirmation: <i>By signing below, I confirm I was present during and directly observed the entire contact between the patient and the practitioner</i>	Date and Time signed by chaperone	Practitioner signature:	Date and Time signed by practitioner

I confirm the above entries were completed with both the chaperone and I in attendance and are an accurate representation of all patients where a chaperone was required to be present to directly observe the entire contact.

I confirm that prior to each and every contact with a patient requiring a chaperone, the patient was offered the choice of:

- the use of a chaperone approved by the Health Ombudsman; or
- an appointment/contact with another registered health practitioner instead.

Practitioner Signature: _____

Date: _____

**Office of the Health
Ombudsman**

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