



## Adult vaccination/blood test consent form

Please complete all the white boxes and bring the completed form to your first appointment.

### Personal Details:

|  |                               |  |                            |                           |  |
|--|-------------------------------|--|----------------------------|---------------------------|--|
| First Name                                 | <input type="text"/>          |  | Last Name                  | <input type="text"/>      |  |
| Gender                                     | Male <input type="checkbox"/> |  | Female                     | <input type="checkbox"/>  |  |
| Date of Birth                              | Day <input type="text"/>      |  | Month <input type="text"/> | Year <input type="text"/> |  |
| Contact Number                             | <input type="text"/>          |  | Alternate Number           | <input type="text"/>      |  |
| Allergies                                  | Yes* <input type="checkbox"/> |  | No                         | <input type="checkbox"/>  |  |
| *if Yes, please list: <input type="text"/> |                               |  |                            |                           |  |

Do you have immune deficiencies? Yes  No

Any known other conditions (please describe):

I hereby consent to be immunised against (please tick):

|                          |             |                          |                             |
|--------------------------|-------------|--------------------------|-----------------------------|
| <input type="checkbox"/> | Chicken pox | <input type="checkbox"/> | Meningitis C                |
| <input type="checkbox"/> | Td/IPV      | <input type="checkbox"/> | Polio                       |
| <input type="checkbox"/> | Hep A       | <input type="checkbox"/> | Influenza                   |
| <input type="checkbox"/> | Hep B       | <input type="checkbox"/> | Other: <input type="text"/> |
| <input type="checkbox"/> | Typhoid     |                          |                             |

I hereby consent to a blood test for:

Patient signature  Date

GP Name

GP Address

GP Contact Number

Next of Kin Name  Contact Number

Please check the following that apply to your immediate biological family:

|                                  |                          |                |                          |
|----------------------------------|--------------------------|----------------|--------------------------|
| Asperger's Syndrome              | <input type="checkbox"/> | Diabetes       | <input type="checkbox"/> |
| Asthma                           | <input type="checkbox"/> | Eczema         | <input type="checkbox"/> |
| Crohn's Disease                  | <input type="checkbox"/> | Heart problems | <input type="checkbox"/> |
| Other illness (please describe): | <input type="text"/>     |                |                          |

# Financial Consent

This is an agreement between the Patient

(Patient's Full Name) \_\_\_\_\_ (Date of Birth) \_\_\_\_\_  
of (Full Address) \_\_\_\_\_  
\_\_\_\_\_  
(Post Code) \_\_\_\_\_ (Telephone no.) \_\_\_\_\_

(hereinafter to be referred to as *The Patient*) and  
**Breakspear Medical Group Ltd,**  
of Hertfordshire House, Wood Lane, Hemel Hempstead, Hertfordshire,  
HP2 4FD (hereinafter referred to as *Breakspear Medical Group*).

The Patient hereby agrees to pay Breakspear Medical Group for consultations, treatment, tests and testing, pharmacy, vaccines and other supplies, and accommodation and meals provided at the rate applicable at the time of the treatment.

Signed by The Patient

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

Approved on behalf of Breakspear Medical Group by:

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

## - This section is optional -

The preferred method of payment is by credit or debit card and The Patient hereby authorises Breakspear Medical Group to collect payment from their card, details of which are set out hereunder:

Credit card type: \_\_\_\_\_  
Card number: \_\_\_\_\_  
Expires end (mm/yy): \_\_\_\_\_ If Switch, Issue number: \_\_\_\_\_  
Name as appears on card: \_\_\_\_\_  
Authorised signature: \_\_\_\_\_

## Breakspear Medical Group Use Only

|                                       |  |                    |  |
|---------------------------------------|--|--------------------|--|
| Date :                                |  | Temperature:       |  |
| General Health on day of vaccination: |  | Injection site:    |  |
|                                       |  | Batch number       |  |
|                                       |  | Exp Date:          |  |
|                                       |  | Make:              |  |
| Vaccine Type:                         |  | Dose:              |  |
| Doctor's signature:                   |  | Nurse's signature: |  |