



## First visit adult treatment consent form

To be completed by patients 16 years of age or older prior to the first consultation at the clinic.

I,  Mr  
 Mrs  
 Ms  
 Miss  
 \_\_\_\_\_

First name  Surname

Date of birth (dd/mm/yyyy)

of (address)

(Post code)

(Telephone number)  (Email)<sup>1</sup>

consent to undergoing consultation, examination, clinical tests and treatments, including administration of medicine, the nature and effect of which will be explained to me by a healthcare professional at Breakspear Medical Group.

I also consent to undergoing testing and treatment including administration of medications. I understand that some of the medicines administered are unlicensed and are classed as "Specials" by the Medicines and Healthcare products Regulatory Agency. The implications of this and any possible risks or side effects will be fully explained to me prior to administration.

I understand that there is no guarantee that the procedures will be carried out by a particular member of the clinical staff.

I understand that if I have chosen to provide my email address to Breakspear Medical Group that Breakspear Medical Group may use this method of communication to contact me. I understand that email transmission cannot be guaranteed to be secure or error-free and therefore Breakspear Medical Group does not accept liability for any errors or omissions in the contents of messages, which arise as a result of email transmission.

Tick one of the following boxes:

- I agree** that information from Breakspear Medical Group can be sent to my GP.

Name of GP

Address

Telephone number

- I do not agree** that information from Breakspear Medical Group can be sent to my GP.

Patient's signature  Date

Consent to procedures is recorded in line with the Department of Health Guidance 'Reference Guidance to Consent for Examination or Treatment'.

<sup>1</sup> It is optional to provide your email address.