



First visit child treatment consent form

To be completed by parent/guardian for patients up to 16 years of age on the first visit to the clinic.

Patient Information

The child whose name is entered below will hereby be known as "The Patient" throughout this document.

First name Surname

Male Female Date of birth (dd/mm/yy)

of (Address)

(Post code)

I, (full name of parent/guardian) Mr Mrs Ms Miss _____

First name Surname

of (Address, if different from above)

(Post code)

(Parent/guardian telephone number) (Email)

being the (relationship to patient)

hereby consent to The Patient undergoing consultation, examination, clinical tests and treatments, the nature and effect of which will be explained to me by a healthcare professional at Breakspears Medical Group.

I also consent to undergoing testing and treatment including administration of medications. I understand that some of the medicines administered are classed as "Specials" by the Medicines and Healthcare products Regulatory Authority and are not licensed medicines in the UK. The implications of this and any possible risks or side effects will be fully explained to me prior to administration.

I agree to accompany The Patient at all times while he/she is attending Breakspears Medical Group. I understand that there is no guarantee that the procedures will be carried out by a particular member of the clinical staff.

Tick one of the following boxes:

I agree that information from Breakspears Medical Group can be sent to The Patient's GP.

Name of GP

Address

Telephone number

I do not agree that information from Breakspears Medical Group can be sent to The Patient's GP.

Signature of The Patient (when appropriate)

Date

Signature of parent/guardian

Date

If the above is not the mother, biological father married to the mother or legal guardian a signed letter of authorisation is required from one of the above people.

Signature of Breakspears staff witness

Date



Patient confidentiality information

The Care Quality Commission (CQC), the British health and social care regulator, requires that clinical organisations complete clinical audits using data from patient records.

In order to complete clinical audits/clinical review to improve Breakspear Medical Group's services, we need your permission to use data from your medical records.

Any information used in clinical audits/clinical review is anonymised.

Please indicate below if you are willing for us to use anonymised medical information for these purposes.

Patient details

(The name entered below will hereby be known as "The Patient" throughout this document.)

First name

Surname

Date of birth

Please tick the appropriate box below.

- I do give permission to Breakspear Medical Group to use the medical records of The Patient for the purpose of clinical audits/review, etc.
- I do not give permission to Breakspear Medical Group to use the medical records of The Patient for the purpose of clinical audits/review, etc.

Patient signature
(for patients 16 years of age or older)

Date signed

If signing on behalf of a patient under the age of 16 or an incapacitated adult, complete the following:

Parent/guardian details

First name

Surname

Relationship to patient

Parent/guardian signature
(when applicable)

Date