Breakspear Hospital

First Visit CHILD Treatment Consent Form

To be completed for patients up to 16 years of age.

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

being the (relationship to patient) _____

of (name of patient, hereby referred to as "The Patient")

First name _____ Surname _____

Date of birth (dd/mm/yyyy) _____

of (Address) _____

_____ (Post code) _____

(Telephone number) _____ (Email) _____

hereby consent to The Patient undergoing consultation, examination, clinical tests, treatments and administration of other medications should these be shown to be necessary during the course of the consultation, treatment and testing, which will be explained to me by a healthcare professional prior to administration.

Tick one of the following boxes:

❑ I agree that information from Breakspear Hospital can be sent to The Patient's GP.

Name of GP _____

Address _____

❑ I do not agree that information from Breakspear Hospital can be sent to The Patient's GP.

Signature of The Patient (when appropriate) _____ Date _____

Signature of Parent/Guardian / Grandparent/Registered minder _____ 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 Breakspear staff witness _____ Date _____

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