NHS number:

Name of patient:

Address:

Date of birth:

CR number:

AFFIX PATIENT LABEL

Royal Cornwall Hospitals NHS
NHS Trust

CONSENT FORM 3

For use in Cornwall

PATIENT/PARENTAL AGREEMENT

(Procedures where consciousness not impaired)

Name of procedure or treatment
(including brief explanation if medical term not clear)

Special Requirements (e.g. other language, other communication method etc.)

Responsible health professional

Job title

Statement of Health Professional (to be filled in by health professional with appropriate knowledge of proposed procedure, as specified in consent policy)

I have explained the procedure to the patient/parent. In particular, I have explained:

The intended benefits

Significant, unavoidable or frequently occurring risks

I have also discussed what the procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment) and any particular concerns of those involved.

☐ The following leaflet/tape has been provided

affix patient label

Signed _____ Date _____

Name (PRINT) _____

Job title _____

Statement of Interpreter (where appropriate)

I have interpreted the information above to the patient / parent to the best of my ability and in a way in which I believe they can understand.

Signed _____ Date _____

Name (PRINT) _____

Statement of patient / person with parental responsibility

I agree to the procedure described above.

I understand that you cannot give me a guarantee that a particular person will perform the procedure. The person will, however, have appropriate experience.

I understand that the procedure will/will not involve local anaesthesia.

I agree / disagree that tissue and fluid samples may be used anonymously and stored for quality control and other technical purposes ***[delete as appropriate].***

I agree / disagree that tissue and fluid samples may be used anonymously and stored for clinical education ***[delete as appropriate].***

I agree / disagree that tissue and fluid samples may be used anonymously and stored for ethically approved research ***[delete as appropriate].***

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I have listed below the type of medical research that I do not wish my child's samples to be used for:

Signature _____ Date _____

Name (PRINT) _____

Relationship to patient _____

Confirmation to Consent (to be completed by health professional when the patient is admitted for the procedure, if the patient / parent has signed the form in advance)

I have confirmed that the patient / parent has no further questions and wishes the procedure to go ahead.

Signed _____ Date _____

Name (PRINT) _____ Job title _____