Clifton House Medical Centre consent form

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| --- | --- |
| Patient name |  |
| Patient address |  |
| Patient D.O.B. |  |
| Patient contact number |  |

I give permission for the person/people named below to speak to the staff at Clifton House Medical Centre on my behalf and to continue **until I advise you otherwise**.

Please indicate below specific consent to be given.

|  |  |
| --- | --- |
| Medication |  |
| All health care needs |  |
| Other please state |  |

|  |  |
| --- | --- |
| Name |  |
| Relationship to Patient |  |
| Contact telephone numbers |  |
| Registered carer | Yes/No |

Would you like the above named person to be added to your medical records as your registered carer? If so please indicate above.

|  |
| --- |
| Any other information you feel would help us in caring for you, ie keysafe number. |

Patient signature ………………………………………….. Date …………………………