**The Bridge Surgery, 8 Evesham Road, Headless Cross, Redditch, B97 4LA**

**PATIENT CONSENT FORM**

Consent for a carer, partner, family member or friend to be the patient’s representative when dealing with prescriptions, blood tests results, medical treatment, or other aspects of their care. If you need consent for more than one individual you will need a further form please ask at reception. For patient Safety we ask that you have no more than Two representatives unless there are special circumstances which must first be discussed with the practice manager

**PATIENTS DETAILS**

|  |  |
| --- | --- |
| **Full Name Of Patient**  |  |
| **Date Of Birth:** |  |
| **Address :** |  |
| **Telephone Number**  |  |

**PATIENTS REPRESENTATIVE**

This form authorises the surgery to allow the named representative to deal with aspects of your medical care. This will authorise the surgery to override the normal Caldicott Guardian Guidelines and Data Protection Laws on patient confidentiality and allow your representative to act on your behalf.

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| --- | --- |
| **Relationship to Patient**  |  |
| **Full Name**  |  |
| **Date of Birth**  |  |
| **Address** |  |
| **Telephone Number**  |  |

* I confirm that I understand that by consenting to my representative dealing with my medical care on my behalf, they will know about my medical conditions.
* I also understand that The Bridge Surgery reserves the right to only deal directly with me,

Where they feel it is appropriate to do so.

* I will inform The Bridge Surgery in writing if I wish to withdraw this consent.

|  |  |  |
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| **Signature of Patient** |  | **Date** |

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| **FOR OFFICE USE ONLY:** |
| **Signature of staff member** |  |
| **Date** |  |
| **Photo ID seen** |  |
| **Name of staff member if they are personally vouching for patient** |  |

*This form, once completed, must be kept with the patient’s medical records. A manage note including representatives date of birth and telephone number must be added prior to scanning*