CONSENT and CONFIDENTIALITY

Your information is never passed to any third parties and consent to contact you can be changed at any time. Please tell the receptionist if you require this to be changed.

CONSENT TO TREATMENT

If you would like to receive treatment at New Leaf Healthcare please complete the details below and sign your name confirming that: (a) you have read and understood the information provided and that you will comply with the stated requirements (b) You understand the possible side effects of the medication (c) the replies you make on this form and with the doctor are true.(d) All the information given is correct on the medical history form. Note: it is an offence against the 1971 Misuse of Drugs Act to make a false statement to obtain medicines controlled by this Act

PRINT IN BLOCK CAPITALS

Title …….. Address …… Post Code ……..

First Name …….. …… Date of Birth……

Surname …….. ……

I CONSENT THAT THE INFORMATION PROVIDED TO NEW LEAF HEALTHCARE LTD IS CORRECT AND UP TO DATE.

I AGREE TO INFORM NEW LEAF HEALTHCARE LTD OF ANY CHANGES IN MY CIRCUMSTANCES OR CHANGE OF MEDICATION/TREATMENT.

DOCTORS SIGNATURE: I have explained the treatment plan and possible side effects of the medication:

Signed: **Date:**

PATIENTS SIGNATURE: I have understood the treatment plan and possible side effects of the medication and have received a medication information leaflet

Signed: **Date:**

Written: 2nd January 2020

Reviewed: 30th January 2024

Next Review Date: 30th January 2025