

Appendix 5 Consent

Example of a written NHS Trust consent form

University Hospitals Plymouth NHS Trust

Consent Form 3
Procedures where consciousness not impaired

Patient/Parental Agreement to Investigation or Treatment
(procedures where consciousness not impaired)

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

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 _____
Serious 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 _____

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 s/he/they can understand.
Signed _____ Date _____ Name (PRINT) _____

Statement of Patient/Person with Parental Responsibility for Patient
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 understand that tissue or fluid samples may be used for a number of purposes, including quality control (checking standards), and that they may subsequently be stored if needed for my future care.
I am willing for tissue or fluid samples to be used anonymously for the education of doctors, nurses and other health care professionals. *[delete if you do not agree].*
If you agree, tissue and / or fluid samples taken as part of the procedure may also be used later in ethically-approved research. This may benefit other patients in the future. Please note it is not always possible to make use of donated tissue.
I agree / I object to tissue or fluid samples already taken as part of the procedure being used for medical research *[delete as appropriate].*
I have listed below any type of medical research for which I do not wish my / my child's samples to be used:

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.
Signature _____ Date _____
Name(PRINT) _____ Job title _____

YELLOW TOP COPY FOR HEALTH RECORDS
White copy accepted by patient/ parent: YES or NO (please ring)
N.B. See Guidance to Health Professionals on inside cover

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