Darwen Healthcare

"Where your health matters"

# Patient Video Consultation Consent Form

| | | | |
|---|---|---|---|
| Patients Name | | | |
| Date of Birth | | Phone Number | |
| Address | | | |
| | | Post Code | |
| Patients Whatsapp Identity Details | | | |
| | | | |
| Patients Signature | | Date | |

**In the case of the patient not being able to give consent, the patients name and address should be completed above and the details of the Patients Representative entered below**

| | | | |
|---|---|---|---|
| Name of Patients representative | | | |
| Address | | | |
| | | Post Code | |
| Patient Representative Phone Number | | | |
| Patients Whatsapp Identity Details | | | |
| | | | |

| **Capacity of Representation Please type X in the box that applies** | | | |
|---|---|---|---|
| Lasting Power of Attorney (Health & Welfare) | | Family Member acting as Carer | |
| Parent or Guardian of Child under 16 years | | Care Worker or Care Home Staff | |

| | | | |
|---|---|---|---|
| Patients Signature | | Date | |

After completing the form please save to your hard drive and make a note of the location.

Please click on the link below to open an email and attach the form to the email and click send to forward to the surgery

Mail: darwen.healthcare@nhs.net

Alternatively please print out a copy of the form and hand in at surgery reception.