Please use label

Name:
DOB:
Hospital No.:

Consent OPAT Home IV Service

Patient Copy:
If you are happy with all the information that you have received and have had the opportunity to ask questions and they have been answered to your satisfaction and wish to be registered with the Service, please sign the form below.

The original copy will be kept with your medical notes. You will also receive a copy for your future reference.

I fully understand the OPAT Home IV service as explained to me, I have received a patient information leaflet, and would like to be registered with the Service,
AND
By signing this document, I give consent, in agreement with the Data Protection Act 2018 and in the context of the delivery of the Service, to the collection, processing, transferring and sharing my personal data (which includes information regarding my health, my condition, and my treatment) for the purposes set out above, including (a) providing the Service to me and storing and processing my personal data as has been described in this form, (b) keeping my treating Doctor and his/her team informed about my condition, and(c) treating and reporting any reactions I may experience while receiving the Service , all as explained to me and set out in this OPAT Services and Data Protection Consent Form and information leaflet.

Signature of service user: _____

Print Name: _____ Date: _____/_____/ 20_____

Address: (applicable to both signings)
_____

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