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System Number 21.335

Name: Date of Birth: Room Number:

Consent Form

Date: Time: Examination, care, treatment or support for which it is necessary to obtain consent:

Does the service user have capacity to make a decision about the examination, care, treatment or support stated above? Y / N

If you feel the answer is no and that the service user does not have capacity to make a decision about the care and treatment stated above, please refer to the Mental Capacity Assessment and Best Interests Checklist. If the service user does have capacity to make a decision, please continue overleaf.

I give my consent for the proposed examination, care, treatment or support stated on page one.

Print name of service user:

Signature: Date/Time:

Comments (e.g. if and when the decision needs to be reviewed)

Print name of staff member:

Signature: Date/Time: