

[This Photo](https://en.wikipedia.org/wiki/Society_of_Chiropodists_and_Podiatrists) by Unknown Author is licensed under [CC BY-SA](https://creativecommons.org/licenses/by-sa/3.0/)

**PATIENT INFORMATION AND CONSENT FORM**

**NAME:..................................................................ADDRESS......................................................................................................................................................................................................................POST CODE...........................**

**DATE OF BIRTH: ......................................................HOME TELEPHONE NUMBER: ………………………………………………..**

**MOBILE NUMBER: ...............................................................................................................**

**EMAIL: ................................................................................................................................**

**OCCUPATION: …...................................................................................................................**

**EMERGENCY CONTACT: …....................................................................................................**

**RELATIONSHIP: ....................................................................................................................**

**CONTACT NUMBER: …..........................................................................................................**

**GP: …...................................................................................................................................**

**PRACTICE/SURGERY ADDRESS: ….........................................................................................**

**DATE LAST SEEN BY GP: …....................................................................................................**

**OTHER HEALTH CARE PROFESSIONALS INVOLVED IN YOUR CARE:**

**…..........................................................................................................................................**

**ALLERGIES: ….......................................................................................................................**

**…..........................................................................................................................................**

**MEDICATION NAME: DOSE: FREQUENCY:**

|  |  |  |
| --- | --- | --- |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**I give consent to the following: (please tick or circle those that apply)**

* **Assessment and treatment**
* **Permission to contact next of kin or designated other in an emergency**
* **Share health information with others (GP, Nurse/Social Worker/Family**
* **Permission to take photographs/video for direct clinical purpose, further permission will be sought before they are made public for either consultation with forums, education or publishing**
* **Any information either hard copy, images or uploaded to the electronic patient management system will be kept in accordance to data protection legislation and your information will not be passed onto 3rd parties**
* **The use of caustics (acids) for the treatment of verrucae/warts/corns**
* **The use of cryotherapy (freezing treatments) on verrucae/warts**

**Signed: ........................................................... Date: …..................................................**