Lighthouse Medical Practice

Patient Consent

Name: ______________________________________ Date Of Birth: ____________________

We want to be able to contact you in the easiest and most efficient way possible. This could be on the phone, via text or email. Being able to do things this way saves time for you and us.

This is to confirm that I give my permission for information/messages regarding medical and/or administrative matters to be: *(Please tick boxes as applicable)*

1. **LEFT ON MY ANSWERPHONE BOTH ON MY LAND LINE AND/OR MOBILE TELEPHONE** ☐
2. **SEND TO ME VIA TEXT MESSAGES TO THE TELEPHONE NUMBER BELOW** ☐
3. **SEND VIA EMAIL TO THE ADDRESS GIVEN BELOW** ☐
4. **LEFT WITH THE FOLLOWING PEOPLE** ☐

Name: ________________________________ Relationship: ____________________ Tel:______________________

Name: ________________________________ Relationship: ____________________ Tel:______________________

Is there anything we need to know about you in order to help us communication with you e.g. hearing impairment?

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……..

Is there something that we can do practically to help us communicate with you better e.g. Form or method of communication, or print size?

……..

……..

Do you need anyone to help you communicate with us e.g. interpreter or advocate?

……..

……..

IN ORDER TO MAINTAIN OUR RECORDS, PLEASE CAN YOU ALSO CONFIRM THE FOLLOWING:

Emergency Contact Number:________________________ Email Address:__________________________________

Mobile telephone number:___________________________ Landline telephone number:_______________________

Signed: ____ Date:___________________