First Adult Treatment Consent Form

To be completed by patients 16 years of age or older prior to the first consultation

Title (please tick):

- ☐ Mr
- ☐ Mrs
- ☐ Ms
- ☐ Miss

First Name

Surname

Date of birth (dd/mm/yyyy)

E-mail

Address Line 1

Address Line 2

Post code

Telephone number

Mobile number

(hereafter referred to as The Patient) consent to undergoing consultation, examination, clinical tests and treatments, the nature and effect of which will be explained to me by Dr. Prem Bajaj, Medical Director, Modern Health.
I also consent to undergoing testing and treatment including administration of other medications. I understand that it is the policy of Modern Health to use and administer medicines in the purest form and if pure medicines without preservatives are not available, appropriate “specials” will be acquired. I understand that many of the medicines being administered at Modern Health are not licensed medicines and fall under the Medicines and Healthcare products Regulatory Agency “specials” law, which states that a British Registered Physician may order, prescribe and administer any medicine or preparation for his or her patient and assume medico-legal responsibility for these actions. I consent to the administration of these medicines, if required.
I also understand that the same criteria apply to medicines being used outside the terms of their licence, or ‘off-label’. (This is when a medicine is used for any purpose for which it is not licensed, or in a dosage, or form of delivery, for which it is not licensed.) I also consent to the administration of these medicines, if required.
I understand that there is no guarantee that the procedures will be carried out by a particular member of the clinical staff.
I understand that if I have chosen to provide my email address to Modern Health that Modern Health may use this method of communication to contact me. I understand that email transmission cannot be guaranteed to be secure or error-free and therefore Modern Health does not accept liability for any errors or omissions in the contents of messages, which arise as a result of email transmission.

Tick one of the following boxes

☐ I agree that information from Modern Health can be sent to my GP.

Name of GP

Address

Telephone number

☐ I do NOT agree that information from Modern Health can be sent to my GP.

Name in BLOCK letters

Signature of The Patient (print and sign)

Date

Signature of Healthcare Professional

Date

*Required information.