VINCYP
Visual Impairment Network for Children & Young People

NHS SCOTLAND

# Consent / Information Form

Please Tick

I give permission for my/my child's information to be shared with professionals from other visual impairment agencies: ☐

- Education Services
- Social Services
- Voluntary Agencies

I have been informed that my/my child's information will be entered into the clinical audit system and that I may be contacted by VINCYP to provide me with information which may be helpful to me/my child and/or to request my help regarding research. ☐

Name of patient_______________________________________________

Patients date of birth/CHI:____________________________________

Name of parent/guardian if applicable: _________________________

Signature of patient/guardian__________________________________

Date:_____________________________________________________

Witnessed by (this signature is only needed if the form is being signed by a health professional): ____________________________________

Date ___________________________

1. Patient information entered into the CAS Date............................ ☐

2. Information leaflet given or posted to patient Date......................... ☐

*A copy of this form will be kept in the case notes.*