DOLAN'S PODIATRY

Consent to Assessment & Treatment

Practitioner: Michelle Dolan
HCPC Registered Chiropodist/Podiatrist – CH34864

Patient details

Name: _____

Date of birth: _____

Date: _____

Assessment and treatment

I understand that my podiatrist will assess my feet and lower limbs as clinically appropriate and will explain the proposed treatment to me.

I have had the opportunity to ask questions.

I understand that:

- I can ask questions at any stage;
- I can refuse treatment;
- I can change my mind and withdraw consent;
- treatment may involve some discomfort, minor bleeding or other risks depending on the procedure;
- I should tell my podiatrist about relevant medical conditions, medication, allergies and changes in my health;
- I should follow any aftercare advice provided.

Consent

I consent to assessment and treatment by Michelle Dolan.

☐ Yes

☐ No

Specific treatment

Where relevant, the treatment proposed today is:

Any significant risks, alternatives or relevant information discussed:

Clinical photography

Photographs may be taken where clinically useful to document or monitor treatment.

I understand that clinical photographs form part of my confidential clinical record.

☐ I consent to clinical photographs being taken where clinically appropriate.

☐ I do not consent to clinical photographs.

Non-clinical photography

I understand that photographs intended for advertising, social media, education or promotional purposes require separate permission.

☐ I consent to appropriate anonymised photographs being used for this purpose.

☐ I do not consent.

Patient declaration

I confirm that I have understood the information provided and have had the opportunity to ask questions.

Patient signature: _____

Date: _____

Parent / person with parental responsibility / representative

Where applicable:

Name: _____

Relationship / authority: _____

Signature: _____

Date: _____

Practitioner

Signature: _____

Date: _____