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CONSENT

To help your child and ensure a coordinated approach we may need to liaise with/ send copies of reports to/ request information/ reports from other Health Professionals e.g. School Nurse, G.P., CAMHS Services including step 2 and PALMS) or professionals from other agencies (e.g. Education Specialist Teachers, Educational Psychologists, School, Social Care).

Are you happy for the ADHD Community Paediatric Team to liaise with professionals from other agencies?

Send copies of reports	YES ☐	NO ☐
Request Information	YES ☐	NO ☐
Face to Face/ Telephone/Email contact as necessary	YES ☐	NO ☐
I give consent for the ADHD Community Team to see my child for intervention in any appropriate setting such as clinic, school or home	YES ☐	NO ☐
I am happy for the ADHD Community Paediatric Team to Contact me Face to Face, Telephone, Emails and Texts as appropriate	YES ☐	NO ☐

If you choose not to give consent it will in no way affect your right to treatment, but may affect the depth of the service we can give your child.

Form Completed by person with parental responsibility:

Name:
Signed:
Date:

Name of child:
Date of Birth:
NHS Number:

Please kindly return these forms to your GP surgery **before** your child's appointment: