

BLUEBELL WOOD CHILDREN'S HOSPICE



CONSENT TO CONTACT CHILD/YOUNG PERSON'S DOCTORS AND OTHER PROFESSIONALS

Please complete ALL THE DETAILS on this form in BLOCK CAPITALS

Parent(s)/Carer(s) Name			
Child/Young Person's Name			
Date of Birth			
Address			
Home Telephone No:		Mobile Telephone No:	
Ethnic Origin:	Religion:	First Language:	
Child/Young Person's NHS Number:		PCT:	
Mother's E-mail:		Father's E-mail:	
Signature of Parent/Carer:			
Brothers and Sisters			
Name:	.....	DOB:	..... (Male/Female)
Name:	.....	DOB:	..... (Male/Female)
Name:	.....	DOB:	..... (Male/Female)
Name:	.....	DOB:	..... (Male/Female)

I/We consent to you contacting:

Family Doctor:	Consultant Paediatrician:
Address:	Address:
Post code:	Post code:
Telephone Number:	Telephone Number:

And any other professional, ie, Social Worker, Community Nurse

Name:	Name:
Profession:	Profession:
Address:	Address:
Post code:	Post code:
Telephone Number:	Telephone Number:

Attends school	YES/NO
Name of School:	

This consent form will be used for initial assessment and future reviews
Please return this form in the envelope provided. Thank you