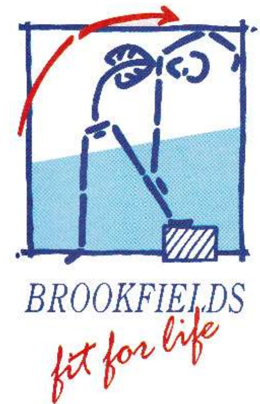
TREATMENT CONSENT FORM



Title

First name

Surname

Address

Post Code

Telephone Home Work Mobile

Occupation

D.O.B GP name:

Referred by GP: Consultant: Self:

Insurance Co Name: Membership No: Claim no:

Is this your first visit to Brookfields Yes No

Medical History

Stroke/TIA	Yes No	Incontinence	Yes No
Cardiac/Heart problems	Yes No	Bladder/Bowel Problems	Yes No
PACEMAKER	Yes No	Cancer	Yes No
Blood Pressure	Yes No	Recent Surgery	Yes No
Chest Conditions	Yes No	Metal Implants	Yes No
Diabetes	Yes No	Weight Loss/Gain	Yes No
Epilepsy	Yes No	Infections	Yes No
Blackouts	Yes No	Vertigo	Yes No

Medication please list

I understand that I am to receive a course of Physiotherapy/Hydrotherapy at Brookfields Physiotherapy Clinic. The nature of the therapy and the desired outcome of the treatment has been explained to me. I consent to this treatment.

I understand that I am ultimately responsible for settling all accounts in relation to this treatment and for any goods purchased.

If applicable it is my responsibility to have prior authorisation from my insurance company and I am responsible for sending invoices to them and all communication with them.

Please note that we have a 24 hour cancellation policy. Cancellations made within this time period will be charged at full rate.

Signed Date

Print Name

Signed/Physiotherapist Date

Print Name