|  |  |
| --- | --- |
| **NEUROSCIENCES UNIT**  **Consent Form** | Med Rec No:………………………………………  Surname:………………………………………….  Forename:…………………………………………  Sex: ………………………………  D.O.B:…………………………… |
| **CANAC CONSENT FOR ASSESSMENT** | |
| I (parent/guardian), \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  consent to my child, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ being assessed by the staff at the Neurosciences Unit and understand that the assessment and subsequent treatment plan (Individual Service Plan) / outcome of assessment will be discussed with me.  Parent/Guardian signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Patient signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |