

## Health Education North East Trauma & Orthopaedic Training Courses

### Patient Recruitment Form

Patient details

Providing Consultant:  
Providing Trainee:  
Providing Hospital:

Patient Name:  
Patient age:

Contact details:  
Phone number:  
Mobile number:

Time of agreed attendance (delete where appropriate)

**Morning / Afternoon / All Day**

**Future course / exams**

Taxi needed?

Clinical diagnosis of the case:

Please complete the Patient Consent Form overleaf and email completed form to Trudie Heron at [trudie.heron@nhs.net](mailto:trudie.heron@nhs.net)



## CONSENT FORM

**For adults/competent children who have capacity to consent**

### **Patient Agreement to taking part in a training course**

Title of Course.....

Name of person taking consent (Responsible Health professional):..... Job title:.....

#### **Statement of health professional.**

I have explained the purpose of the training course and the patients role within it. I have discussed what participation is likely to involve and (if applicable) any associated benefit or risk to the patient. I am satisfied that the patient has capacity in line with the Mental Capacity Act to consent to taking part in the training day.

Signature of person receiving consent (Trainer/Trainee)

Signed..... Date.....

Name (PRINT)..... Job Title.....

Contact details (if patient wishes to discuss participation later) Trudie Heron – 0191 275470 or [trudie.heron@nhs.net](mailto:trudie.heron@nhs.net)

#### **Statement of Patient**

Please read this form carefully. If you have any further questions, do ask – we are here to help you. You have the right to change your mind at any time, including after you have signed this form.

1. I confirm that I understand why I have been asked to take part as a patient in this training course. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.

3. (If appropriate) I understand that relevant sections of my medical notes and data collected during the course, may be looked at by Health Education North East Trainees and course trainers, where it is relevant to my taking part in this training course. I give permission for these individuals to have access to my records.

4. (If appropriate) I understand that the information collected about me will be used to support other training in the future, and may be shared anonymously with other course coordinators.

5. I agree to take part in the above training course.

Patient's signature..... Date.....

Name (PRINT).....

A witness should sign below if the patient is unable to sign but has indicated his or her consent.

Signed..... Date.....

Name (PRINT).....