

**Consent for Treatment by an Occupational Therapist or Physiotherapist  
Camden Occupational Therapy and Physiotherapy Service for Children and Young People**

Swiss Cottage School – 80 Avenue Road, London NW8 6HX ☎0207 483 6060/66

Kentish Town Health Centre – 2 Bartholomew Road, London NW5 2BX ☎0203 317 2200

Royal Free Hospital – Children’s Therapy Room, Lower Ground Floor, Pond Street, London NW3 2QG ☎0207 8302535 ☎02074726629

**Please read each section of this form and sign the relevant sections. If you have any queries, please contact the Occupational Therapist or Physiotherapist on the telephone number above.**

**CONSENT FOR TREATMENT BY AN OCCUPATIONAL THERAPIST OR PHYSIOTHERAPIST (please circle)**

I (parent/carer’s name) .....

I give consent for my child (child’s name) .....DOB.....

to be seen by the Occupational Therapist/Physiotherapist, for assessment and/or management of his/her functional skills. Your child’s therapy record will be kept on Camden’s shared health and social care electronic information system called SystemOne. Please note this is a shared record with other health and social care professionals involved in your child’s care.

Yes [ ] No [ ]

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

I give consent to be contacted by phone : .....

I give consent to be contacted or reminded of appointments by text

I give consent to be left a voicemail

I give consent to be contacted by email : .....@.....

**CONSENT TO SHARE INFORMATION WITH EDUCATION AND OTHER RELEVANT PROFESSIONALS:**

I agree that the Occupational Therapist/Physiotherapist may make contact and share information, such as reports (verbally and in writing) with other professionals involved in my child’s care.

Yes [ ] No [ ]

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

**CONSENT FOR STUDENTS:**

I understand that this department is involved in the teaching and training of student Occupational Therapists/Physiotherapists. I give consent for a student Occupational Therapist/Physiotherapist to work with my child, under supervision from a qualified Occupational Therapist/Physiotherapist.

Yes [ ] No [ ]

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

**THERAPY AGREEMENT AND ATTENDING/LEAVING ALONE:**

Please read & tick to show that you have read & understood the following

- A large part of my child’s Physiotherapy will be carrying out an exercise Programme at home. By consenting to treatment I am happy to ensure that this exercise programme is carried out regularly at home & to let the Physiotherapist know if there are any problems
- I understand that if this is not carried out my child may be discharged from Physiotherapy
- I understand that if my child is 10 minutes late they may not be seen and will have to re-book their appointment
- I understand the discharge policy & if my child does not attend 2 appointments (without cancelling 24 hours prior to the appointment) that they will be discharged from Physiotherapy. This also includes turning up over 10 minutes late to an appointment
- I will ensure that my child is appropriately dressed for each session (with shorts and t-shirt as required) and understand that if they are not they may not be treated
- I am happy and consent for my child to attend review appointments on their own (If patient is 14 years or older or deemed Gillick Competent)

Yes [ ] No [ ]

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

**Countersigned: OT/Physiotherapist/Therapy Assistant**

Name .....

Signature.....