

**CONSENT FORM PATIENT COPY**

Name of Patient .....

Date of Birth .....

I ..... consent and agree to move out of hospital (South Warwickshire NHS Foundation Trust) and undertake a short stay at .....  
 .....to enable further assessments to take place to help me decide what future support I require.

I understand that future assessments will involve collecting confidential information from both health sources and Social Services. I am aware that I shall move to .....  
 .....up to a maximum of six weeks.

I understand that I may be charged for my accommodation once my future care is agreed.

***In cases where the person is unable to give consent a suitable representative must sign on behalf of the individual.***

Print Name of patient/representative .....

Signature of patient/representative .....

Relationship to Patient .....Date .....

**Capacity of Authority**

Enduring power of Attorney (signed prior to 1<sup>st</sup> October 2007).

Lasting Power of Attorney

-Health & Welfare

-Finance & Property

Next of Kin

If no patient representative – best interest’s IMCA involved

Name of IMCA .....Date Best Interest.....

***Please note copies of all relevant documents will be required.***