

Record of Patient/Client Consent – Sensitive Personal Data

The Hospice computerised patient/client record system forms part of the shared NHS medical records system called 'SystemOne', and the Health and Social Care System. We are committed to providing the best possible care at Saint Catherine's. In order to do this, authorised clinical staff, auditors, researchers or regulatory organisations e.g. Care Quality Commission, may require access to collect, process and share your personal records which may contain sensitive personal data. Sensitive personal data is defined as information relating to any of the following: racial or ethnic origin, political opinions, religious beliefs, trade union membership, health, sexuality or sex life, offences and/or convictions. We may share your clinical and social care records with other health and social care professionals/organisations involved in your care. The law says we must get your consent for this. **(Data Protection Act 1998)**

The Hospice is registered with the Information Commissioner's Office for Data Protection and is committed to treating your sensitive personal data confidentially and in accordance with the principles of the Data Protection Act. For the purposes of the Act, the Hospice Data Controller is the Chief Executive of Saint Catherine's Hospice, Mr Mike Wilkerson.

I give my consent to Saint Catherine's Hospice:

collecting, processing and sharing sensitive personal information about me with Hospice health and social care professionals.

viewing my full medical and social care records, including my GP medical record on the NHS computerised shared medical record system. **(Sharing IN)**

In order to do this I must inform my GP practice that I consent to this

sharing personal information collected about me at Saint Catherine's Hospice with other NHS care services on the NHS computerised shared medical record system **(Sharing OUT)**

I understand that if I wish to cancel this consent I must inform both Saint Catherine's Hospice and my GP Practice.

Name:

Date of Birth:

Address:

NHS no:

Patient Signature:

Date:

If the patient is unable to sign this form please state why:

If the patient **has capacity** - consent obtained and signed in presence of patient by:

Name:

Signature:

Designation:

Date:

If a patient **lacks capacity** and a best interest decision has been taken to consent for sharing in/out of sensitive personal data:

Date and location (e.g. SystemOne) of Capacity and Best Interests assessment:

Name:

Signature:

Designation:

Date:

Further information:

PALCALL CONSENT FORM (CONFIDENTIAL)

_____ has explained to me the purpose of the Palcall service. I understand that, for the purpose of providing me with the service, advice and information about my condition may be accessed by me and the following people:

Any doctor or nurse attending me plus the following named people (please include main carers)

<u>FULL NAME</u>	<u>RELATIONSHIP</u>	<u>TELEPHONE NO</u>
1 _____	_____	_____
2 _____	_____	_____
3 _____	_____	_____
4 _____	_____	_____
5 _____	_____	_____
6 _____	_____	_____
7 _____	_____	_____
8 _____	_____	_____
9 _____	_____	_____
10 _____	_____	_____

I understand that information that I have given to Palcall may be used, without identifying me, for audit purposes

Print (patient) _____

Signed (patient) _____ Date

Witnessed Print (referrer) _____

Witnessed Signed (referrer) _____ Date

If the patient is unable to sign this form please state why:

If the patient **has capacity** - consent obtained and signed in presence of patient by:

Name:

Signature:

Designation:

Date:

If a patient **lacks capacity** and a best interest decision has been taken to consent for sharing in/out of sensitive personal data:

Date and location (e.g. SystemOne) of Capacity and Best Interests assessment:

Name:

Signature:

Designation:

Date:

Further information:

PTO