Clinical Photography / Video Consent Form

NHS Lothian

Patient Details	Referral Details
Surname:	Date:
Forename:	Ward / Dept:
CHI No:	Consultant:
D.O.B.: M / F	New Pt. ◯ Old Pt. ◯ In-Pt. ◯ Out-Pt. ◯

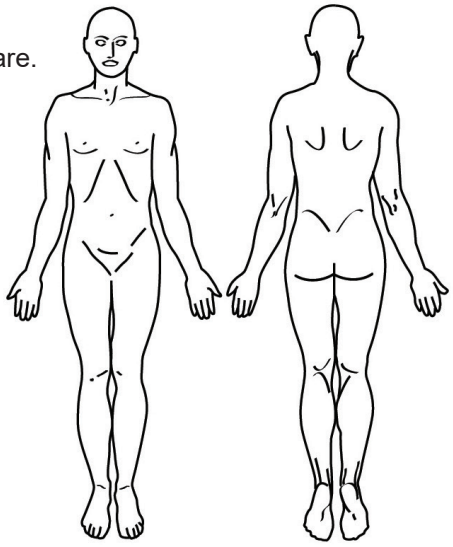
Consent to treatment (Level A)

The patient consents to the recording being made as part of their clinical care.

I have explained the purpose of the recording, how it will be used, and how it will be stored.

Healthcare Professional signature:

◯ Please tick if the patient does not have the capacity to consent, and an **Adults with Incapacity** (AWI) form has been completed.



◯ Millimetre scale (in close-up view)

◯ Dermatoscopic image (LB / SJH only)

◯ Video

Diagnosis / clinical details (please provide clear information)

Interpreter signature / print name:..... **or Telephone ID number:**.....

Consent for secondary use of personal data

Only complete this section if recordings are required for secondary use. Your choice of consent will not affect your treatment in any way, and you can withdraw consent for secondary use at any time by writing to Health Records (Legal Services) Royal Infirmary of Edinburgh, 51 Little France Crescent, Edinburgh, EH16 4SA.

I am: ◯ **the patient** ◯ **person with parental responsibility**	**Agree**	**Disagree**
Consent for Teaching (Level B) I consent to the recordings being used to teach medical, dental, nursing and other healthcare staff and students.	◯	◯
Consent for Publication (Level C) I am happy to be contacted to discuss consent if my recording is requested for publication.	◯	◯
Patient to Patient (Level D) I consent to my images / recordings being shown to other patients as an example of pre / post clinical procedures.	◯	◯

Patient signature: ..... **Date:** .....

For Department Use Only			
Photographer:	Camera / Smart Card No:	Job Reference:	Comments:
Image Date:	No. of Images:	Completion Date:	

◯ Lauriston ◯ PAEP ◯ RHCYP ◯ RIE ◯ SJH ◯ WGH ◯ Other

MPS v2.0 (Clinical) Approved: Aug 2024 / Review Aug 2027