

VITAMIN B12 INJECTION CONSENT FORM PLEASE FILL IN ALL DETAILS

Your information has been requested to record your treatments – this includes personal and medical information for our consultation. I will share this only with our in-house registered prescribers for the purposes of assessment and monitoring. For your information:

* Your personal data is kept securely on our database for reference, and physical paperwork is also kept securely in one place.
* I will not share any sensitive or personal information with any other party.
* I will only store your personal information for as long as is necessary and you have a right to view this information or withdraw consent at any time.
* Policies are reviewed annually.

Please confirm that you consent to receive treatment of **1ml Hydroxocobalamin** and give consent to my holding and sharing your information as stated above.

# **YOUR DETAILS**

|  |  |  |  |
| --- | --- | --- | --- |
| TITLE (MR/MRS/MS) |  | EMAIL ADDRESS |  |
| FIRST NAME |  | TELEPHONE |  |
| LAST NAME |  | DOB |  |
| SIGNED |  | DATE |  |

|  |
| --- |
| YOUR HOME ADDRESS |
|  |
| CITY |  | POSTCODE |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **NAME** | **SIGNED** | **BATCH NUMBER** | **DATE** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**REPEAT PRESCRIPTION**

I consent to having my treatment on the above date(s) as well as no changes to my prescription

|  |  |  |  |
| --- | --- | --- | --- |
| **NAME** | **SIGNED** | **BATCH NUMBER** | **DATE** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**REPEAT PRESCRIPTION**

I consent to having my treatment on the above date(s) as well as no changes to my prescription