

CONSENT FORM FOR THE INVOLVEMENT OF THE HEALTH TRANSITION TEAM

Return to: The Health Transition Team
Walsall CDC
Coalhealth Lane
Shelfield
Walsall, WS4 1PL
Tel 01922 639372
healthtransitionteam@walsall.nhs.uk

*Please delete one option where indicated

I or
I, am the parent/ guardian* of
..... (print name of child) my/his/her Date of Birth is

Permanent Address:

.....
.....
.....
.....

Postcode:

Contact Telephone Numbers:

Home:
Mobile:
Work (optional):

GP: GP Address:

1. I do/do not* agree to the involvement of the Health Transition Team
2. I do/do not* agree for to appropriate information being shared with other agencies involved. (for example, physiotherapy, occupational therapy, school, college etc.)

We would prefer an appointment at Home* / School */ Clinic*

Do you need an interpreter Yes/No* If so what language do you use?

Signature of young person/parent/ guardian:

Date: