The Royal Liverpool and Broadgreen University Hospitals NHS Trust

Consent to Clinical Photography Forms

Please ensure you have read and are familiar with the Trust's Clinical Photography Policy prior to performing Clinical Photography or consenting patients for same.

The Royal Liverpool and
Broadgreen University Hospitals
NHS Trust

PATIENT INFORMATION

Consenting to Clinical Photography or Video recording

The Royal Liverpool and Broadgreen University Hospitals NHS Trust has a policy to give you the right to control the use of photographs or video recordings, which may be taken during the course of your treatment.

You can refuse to have photographs or videos taken for any reason other than for your health records. This will not affect your treatment in any way.

You have been asked to have medical photographs or video recordings taken. These will be for:

1. Your health record - you may not be asked for your written consent for this.
2. The teaching of health professionals and students studying healthcare here and in other hospitals/colleges/universities.
3. The education of patients with conditions similar to your own.
4. For publication in Medical and Scientific Journals or Textbooks either now or at any time in the future or for some other specific use that will be explained on the consent form.

You will be given information about what the recordings will be used for in numbers two, three and four above, and will be asked to sign a consent form.

You can say yes to as many or as few of the above as you wish. Please be aware that once photographs have been published, you cannot withdraw your consent.

Further Information

If you have any further questions please speak to your doctor or nurse.

Author: Clinical Photography Sub-Group
Date: July 2006
Review Date: August 2008

This leaflet is available in large print, computer disc, Braille, audiocassette and other languages on request.

Communications and Marketing system job number

The Royal Liverpool and Broadgreen University Hospitals NHS Trust

Complete only if requesting Clinical photography team to perform Clinical Photography

Please PRINT using **BLACK** ink. Give / Send to Clinical photography, Ext 2880 / 2886 / 2890

Requested by

Name .....

Department .....

Directorate .....

Contact No ..... Date ...../...../.....

Signature .....

Patient Details / ID Sticker here

Surname/family name.....

Forenames .....

Date of Birth .....

NHS number .....

Unit number .....

Male ☐ Female ☐

Media format

Colour Print ☐ No. of copies .....

Digital Image ☐ No. of copies .....

Video Recording ☐ contact Medical Illustration to discuss

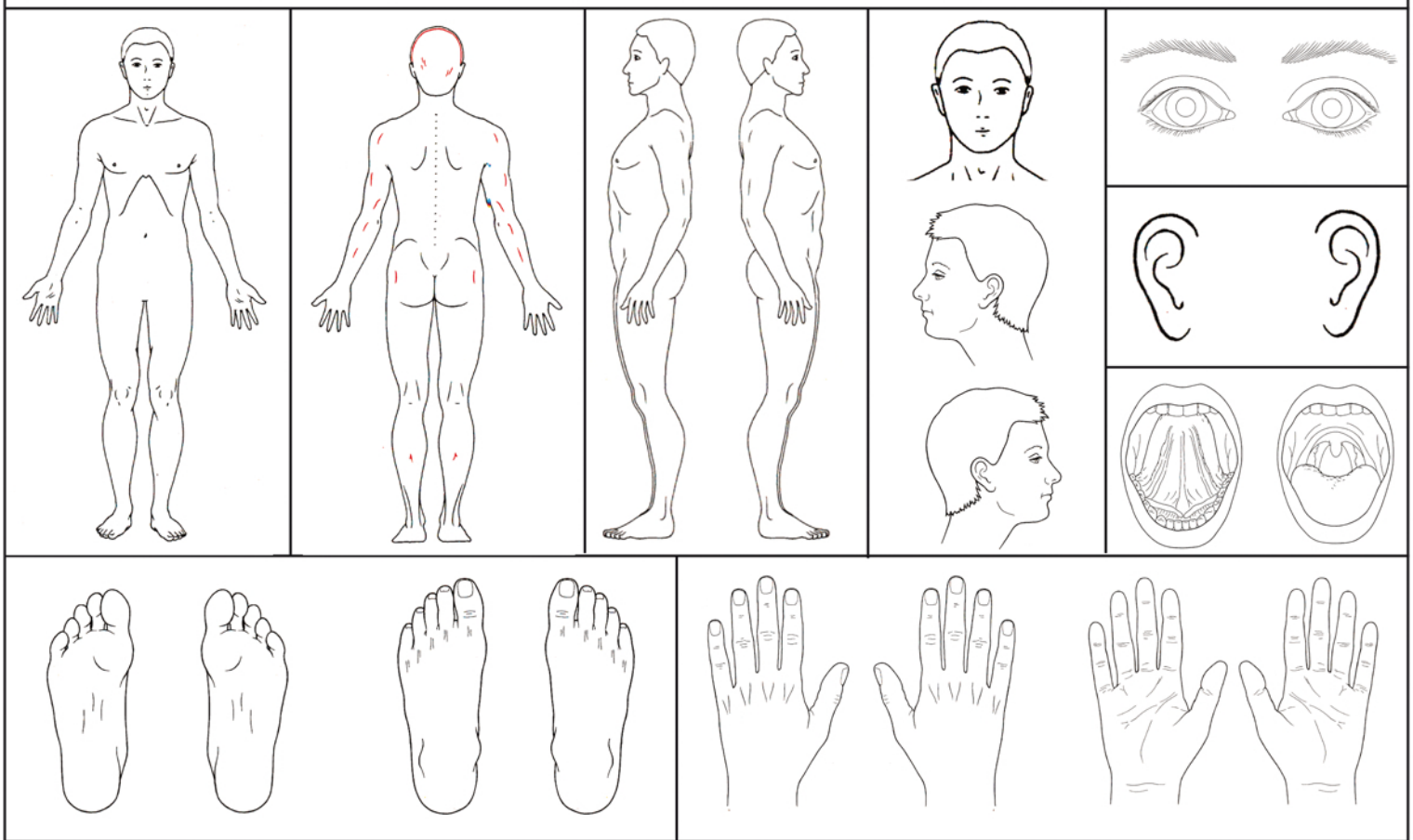
Consent Level

Pleast tick each level agreed with the patient as stated on Clinical Photography Consent form

CL1 ☐ **CL2** ☐

CL3 ☐ **CL4** ☐

Please outline views / areas required



Is a scale / measure required on close ups Yes ☐ No ☐

For Clinical photography use only

Location of Patient photographed:

RLUH ☐ **BGH** ☐

Studio ☐ **Ward** ☐

Clinic ☐ **Theatre** ☐

Date requested ...../...../..... Date photographed ..../...../.....

Date completed ...../...../..... Ward / Clinic .....

Clinical Photographer .....

Signature .....

Consent to Clinical Photography/Video and Transmission form Please **print** using **Black** ink

The Royal Liverpool and Broadgreen University Hospitals NHS Trust

Clinical photography/video/transmissions to be undertaken by:

Medical Illustration Services ☐
St. Paul's Imaging Unit ☐
Trust registered health professional ☐
Mersey School of Endoscopy ☐

Anatomical area.....

Patient Details / ID Sticker here

Surname/family name.....

Forenames .....

Date of Birth .....

NHS / Unit No.....

I have explained the purpose of clinical photography/recordings to the patient and how the images will be used. ☐

Patient information leaflet has been given. ☐

I am a health professional requesting clinical photography/recording. ☐

I am a Trust registered health professional performing clinical photography/video recordings/ or transmissions ☐

I will ensure that the appropriate images are taken in a dignified manner using approved equipment in accordance with Trust policy. ☐

I will ensure all images used for the purpose of CL4 will **not** identify the patient. ☐

Signature of health professional..... **Print Name** .....

Job Title ..... **Contact details**..... **Date**..... / ..... / .....

Patient statement (please circle your answer)

I agree to have clinical photographs/video recordings/transmissions done. The request for the same has been explained to me and I fully understand what it entails. **Yes** **No**

CL1. I consent to clinical photographs/recordings being taken for my personal health record only. **Yes** **No**

CL2. I consent to clinical photographs/recordings being available for teaching in the health care context. **Yes** **No**

CL3. I consent to my clinical photographs/recordings being used to educate patients undergoing similar treatment within the Royal Liverpool and Broadgreen University Hospitals NHS Trust **Yes** **No**

CL4. I consent to my clinical photographs being published for the specific purpose of ..... and/or* publication in Medical or Scientific Journal or Textbook at any time in the future. (* please delete as appropriate) **Yes** **No**

Signature of patient / parent / guardian* ..... **Date** ...../...../.....

*** Must have parental responsibility for the child**

Relationship to child .....

A witness should sign below if the patient is unable to sign but has indicated his or her consent

Signature ..... **Name (print)**..... **Date** ...../...../.....

Statement of Interpreter **Yes** ☐ **No** ☐ **Not applicable** ☐

N.B if telephone interpretation used, health professional to enter details below

I have interpreted the above information to the patient to the best of my ability and in a way which I believe he or she can understand.

Interpreter's signature .....**Name (print)**.....**Date** ...../...../.....

Yellow copy accepted by patient (please circle answer) **Yes** **No**

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Yellow copy accepted by patient (please circle answer) **Yes** **No**