CORFIELD MEDICAL CENTRE

NEW PATIENT CONSENT FORM

Medication Requests and Patient Behavior

Patient name: _____

Date of birth: _____

Please read the points below before signing.

By signing this form, I understand and agree that:

- Our doctors will not prescribe **Schedule 4 or Schedule 8 medicines** until they have received and reviewed enough of my medical history to prescribe safely.
- I may need to provide **previous medical records, medication history, specialist letters, pharmacy information or photo identification.**
- A doctor may refuse **a new, repeat, replacement or early prescription.** Prescribing is always the doctor's clinical decision.
- **I will behave respectfully** towards doctors, nurses, reception staff, patients and visitors.
- **Aggressive, abusive, threatening or violent behaviour will not be accepted.**
- **If I become aggressive or abusive:** the consultation may be stopped, I may be asked to leave, **police may be called**, and I may be **removed and Banned from the practice.**

☐ **I have read and understood the above conditions.**

Patient / representative name: _____

Date: _____

Signature: _____

Relationship (if applicable): _____

Staff witness: _____

Staff initials: _____

This form does not guarantee that any medicine will be prescribed.