**CELLIER WARD AMENITY ROOM CONSENT FORM**

**Please return completed forms to Cellier Reception**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Title:** | **Patient Surname:** | | | | | | | | **Hospital Number:** | | |
|  |  | | | | | | |  | | | |
| **Sex:** | **Forename:** | | | | | | | **DOB:** | | | |
|  |  | | | | | | |  | | | |
|  | **Address:** |  | | | | | | | | | |
|  |  |  | | | | | | | | | |
|  |  |  | | | | | | | | | |
|  |  | | | | | | | **Post Code:** | | | |
|  |  | | | | | | |  | | | |
|  | **Tel No:** | | | | | | **Date:** | | | | |
|  |  | | | | | | |  | | | |
| **Specialist/Consultant:** | | | | | | | | | | | |
|  |  | | | | | | |  | | | |
| **GP Name:** | | | |  | | | | | | | |
|  |  | | | | | | |  | | | |
| **GP Address:** | | | | | | **Induction Date/ ELCS date/EDD (Delete as appropriate):** | | | | | |
|  | | | | | | **Procedure: CELLIER SUITE POSTNATAL CARE: £150 PER DAY** | | | | | |
| ***Full payment is required prior to the commencement of your stay. By signing this form you agree to debit your card with the amount above.*** | | | | | | | | | | | |
| **THIS IS NOT A PRIVATE SERVICE; YOUR STATUS AS AN NHS PATIENT REMAINS UNCHANGED** | | | | | | | | | | | |
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| **Undertaking to pay:**  **I hereby undertake to pay the Whittington Health NHS Trust a 24 hour rate of £150 in full upon arrival and at the start of any subsequent days for the use of the Cellier Suite Postnatal Care.**  **I acknowledge that if I am required to vacate the room before the 24 hours that has been paid for due to a medical or infection control emergency I will be issued with a full refund. The Trust will have 7-10 working days to issue the payment **  **Data Protection Act: I have been notified of the Data Protection Act as it relates to my data processed by the Trust.**   **I have received a Copy of “How Information About You Will Be Used by WH” **  **I confirm that the room is to a good standard, and that I am happy to pay ** | | | | | | | | | | | |
|  |  | | | | | | |  | | | |
| **Signature of Patient:** | | | **Signature of parent/guardian if patient is under 18:** | | | | | | | **Date:**  **Time:** | |

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| --- | --- | --- |
| **Attending Midwife to complete** | | |
| **The patient has been shown the Amenity room and wishes to proceed with hiring the room at the rate stated on this form **  **The patient meets the eligibility criteria to stay in an Amenity room **  **Date and time the patient enters the Amenity room: Date: Time:** | | |
| **NAME (PRINT)** | **SIGNATURE** | **DATE** |
|  |  |  |