**CELLIER WARD AMENITY ROOM CONSENT FORM**

**Please return completed forms to Cellier Reception**

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| **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** |
|  |  |  |