CAMDEN & ISLINGTON RETINAL SCREENING SERVICE
REGISTRATION, CONSENT AND RECRUITMENT FORM

Title ..... please print details clearly

Surname .....……

Forenames .....

Address .....

....

.....

Date of Birth ..... NHS No ……
Ethnic Origin .....
Sex .....

Date Diabetes Diagnosed .....
Type of diabetes .....

Name & Address of GP .....
.....
.....
.....
If the patient is under the care of a Medical Retinal Hospital Eye Clinic please specify

…….

(The patient will not receive annual recall for screening)

If it is necessary to arrange referral to Ophthalmology please state

Preferred hospital…….

I am happy to be sent regular reminders to have my diabetic eye checks from the Camden & Islington Screening Service. I understand that any information given on this form will be treated in accordance with the data protection act

Patient's signature ..... ref patient registration form
Date.....

Please return to: Retinal Screening Office, Room 21, Jenner Building, Whittington Hospital, N19 5HF or FAX to 020 7288 5052