Sheffield Children's NHS Foundation Trust

Child and Adolescent Mental Health Services

Learning Disability and Mental Health Team

Multi-agency Consultation Forum

Affix Patient Label or Complete
SCH Hospital No: ....
Surname: ....
Forename: ....
Address PostCode: ....
Sex: .... D.o.B. ....
NHS Number:....................................

CONSENT FORM

Client Name: ....

Date: ....

I.. (Print name)

give my permission for *my case/my child's case to be discussed at the Child and Adolescent Learning Disability and Mental Health Team Multi-Agency Consultation Forum. I understand that the meeting will be attended by professionals from Health, Education and Social Services and the purpose of the Consultation Forum has been fully explained to me. I accept that discussion of the case may not necessarily result in a referral to either the CAMHS LD/MH Team or Social Services.

It has been explained to me that I have the right to request that certain information about *me/my child be withheld from discussion and that I have the right to request that agencies specified below are not present during the discussion.

Please list any agencies that you would not like to be present during the discussion about *you/your child.

I agree that this consent form will remain valid until I inform the Child & Adolescent Learning Disability and Mental Health Team Multi-Agency Consultation Forum of my wish to amend or withdraw my consent.

Child/Parent's Signature...

Professional's Signature ....

Designation .... Date ....