DIABETES SCREENING SERVICE
CLIENT CONSENT FORM

Section 1 to be completed by the Pharmacy

Name of Pharmacy

Address of Pharmacy

Pharmacy Stamp

I confirm I have explained to the client how the Diabetes Screening Service works and have assessed their risk factors in accordance with the client questionnaire.

Name of Pharmacist/staff member _____

Signature _____ Date _____

Summary of information of signs, symptoms and risks from client questionnaire completed:

Signs and symptoms	Risks
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Section 2 to be completed by the client undertaking the service

- The information provided is true to the best of my knowledge
- To my knowledge there is no reason why I cannot participate in this service
- I understand and agree to the disclosure of my information being passed to my GP where appropriate
- I consent to my personal data, and results being stored by the pharmacy
- I consent to the use of my anonymised data for statistical purposes
- I understand that I must inform the pharmacist of any change in my medical circumstances
- I understand and have been advised that I may require a further appointment with the pharmacist. In some cases this may involve further tests requested by my GP/Practice nurse

I confirm I consent to a finger prick test being undertaken

Name: _____ Date of birth: _____

Signature: _____ Date: _____