

Clinical Placement Expansion Project (CPEP) Consent Form – Live stream of orthoptic assessment (paediatric version)

Patient name:

Patient date of birth:

Parent/guardian phone number or email address:

Date of assessment:

□ I have been given an information sheet explaining how my child’s orthoptic assessment will be livestreamed, and the purpose of this project.

□ I agree to my child’s orthoptic consultation and assessment being live streamed to orthoptic students at the University of Liverpool, University of Sheffield, Glasgow Caledonian University, and University College London, and the University lecturers. These students have undertaken Data Security Awareness Training and will adhere to the principles of patient confidentiality.

□ I understand that during the consultation, information relevant to the diagnosis and management of my child’s eye condition may be discussed. This may include birth history, previous medical history (including medications), and details about previous eye health and symptoms.

□ I agree to being included in the livestream if I am present during the consultation.

□ I understand that my child’s participation is voluntary and that they are free to withdraw at any time during the assessment. Choosing to withdraw from the project will not affect my child’s care.

□ I consent for my child’s orthoptic consultation to be recorded and the video uploaded to the BIOS learning resource library so it may be used for future teaching sessions (separate video recording consent form required)

Statement of consent on behalf of the patient:

I have read the above description of this initiative and all my questions have been answered to my satisfaction. I voluntarily agree to my child taking part in this project. I understand I will receive a copy of this consent form.

Please ensure the above checkboxes have been ticked, and sign below to show that you agree to and understand the above statement.

Name of patient (printed): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of parent/guardian and relationship to the patient (printed): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of parent/guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

