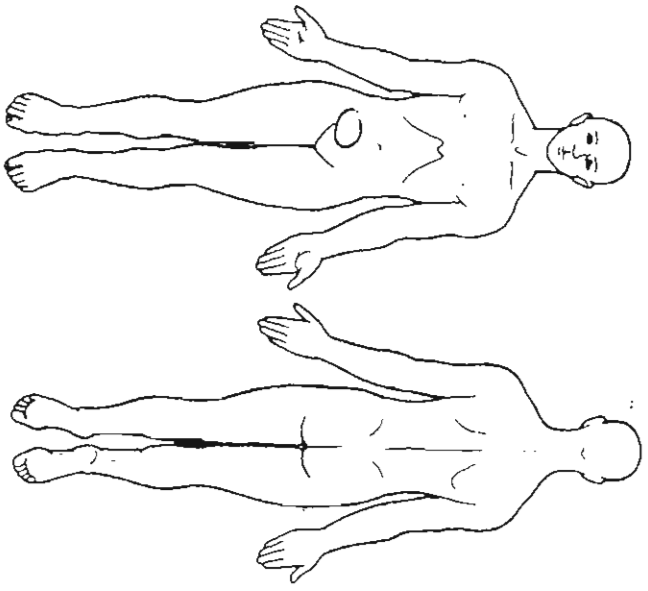
tography/video

F

MP003-02

Views Required
please indicate



For office use

Views taken:

Lens:

Magnification:

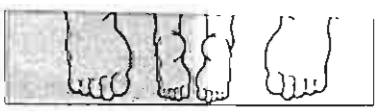
Photographer:

Prints out:

WAS PHOTOGRAPHED

ENT

LEFT



I confirm that I have explained to the patient, parent or their legal guardian,
A The type of photograph required
B The reason why the photograph is being taken → CASES RESEARCH
C I have made a note of any extra comments in the medical record that are appropriate following my discussion with the patient, parent or their legal guardian.

[redacted]

Medical Photography & Illustration Department

Tallaght University Hospital

[redacted]

Images will be available on the Image Management system, please follow link: http://srvwaba:9001/medical

Doctor	Surname: First Name: M/F
Photo no:	Home Address:
Date:	Ward Clinic: Medical Record no: DOB:
Signed:	
Clinical Information	
Photo Required: Also please mark area on back of form	

The patient has given medical record level consent. (Yes)/No ☐

The patient has given teaching level consent. (Yes)/No ☐

The patient has given publication level consent. (Yes)/No ☐

Doctor's/Requestee's Signature _____

Record of a patient's permission to

Addressograp

[redacted]

[redacted]

Tallaght University Hospital
Ospidéal Ollscoile Thamhlachta
An Academic Partner of Trinity College Dublin

Record of a patient's permission to have Medical photography/video

Addressograph or Print Details

Family Name:..... [redacted] ..... Is the patient M ☐ F ☒

First Names.....

M.R. Number.....

Date of Birth.....

Parent's or legal guardian's name: _____
(If this applies).

Consultant's name: [redacted]

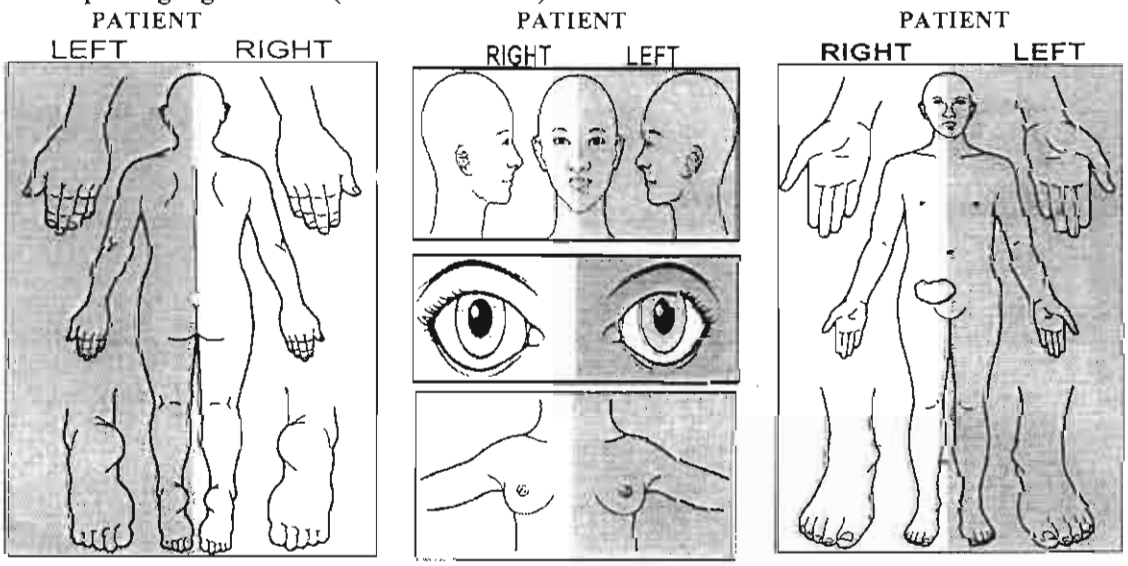
Section 1: The Doctor must fill in this section.

Type of Medical photograph / video (Do Not Use Abbreviations)

INTRA - ORAL PICTURES (CLINICAL PHOTOGRAPHY)

+ X - RAYS.

Site of photograph / video (Mark if relevant)



I confirm that I have explained to the patient, parent or their legal guardian,
A The type of photograph required
B The reason why the photograph is being taken → CASE REPORT
C I have made a note of any extra comments in the medical record that are appropriate following my discussion with the patient, parent or their legal guardian.

PTO

Section 2: The patient, parent or legal guardian, must fill in this section after the doctor has filled in section 1.

- I understand what the doctor has told me about the above medical photograph/ video and I agree to go ahead with it. I know that I can ask about anything I do not understand.
- I have been given a copy of the hospital's patient medical photography Information Leaflet YES or NO (please circle)
- I have checked the details on this form are correct. Y. SJ.
- I understand that the medical photographs will be taken by a medical photographer.

I give consent for images to be used for (Please tick boxes)

Medical Record level consent ☑

Teaching Level consent ☑

Publication Level consent ☑

Patient's signatur [redacted] **Date:** 17/4/19.

Parent's or ~~legal guardian~~'s signatur [redacted] **Date:** 17/4/19
(If appropriate) Ms J

Doctor's signature: [redacted] **Date:** 17/09/19

Doctor's name (please print): O. JAY **Grade:** CONS.

To whom it may concern,

I am writing to you in relation to informed consent and our case report manuscript submitted for consideration for publication in September 2019.

Manuscript Title - ***The Diagnosis of a Painful Right Groin; <u>not</u> as easy as ABC!***

I hereby declare that, following discussion in relation to our intentions to publish this patient's journey as a case report, the patient provided informed consent both verbally and signed off on supporting documentation so that we would be able to use intra-operative imaging.

Please find supporting document attached,

Regards,

16/9/19.

Colum Downey
Orthopaedic Registrar