Central Mersey
Diabetic Retinopathy Screening Programme

Consent for Diabetic Retinopathy Screening

Patient Details

Name ……..……...

Address ……

……..……..….

DOB ……...

I give consent to a Diabetic Retinopathy screening performed by an optometrist accredited to Central Mersey Diabetic Retinopathy Screening Programme. I understand that images will be retained for use in Training and audit within the Cheshire and Merseyside and West Lancashire Screening Programme. (Any such usage will have all personal information removed)

Patient signature: ……. Date: ……...

I also give consent for my optometrist to maintain copies of any images taken in the course of the screening at their practice for the purpose of maintaining my case records within the practice.

Patient signature: ……. Date: ……...

Optometrist Practice

Optometrist signature: ……..…… Date: ……..….