Media Studio Trust Web Page | Clinical Image Library Log In Page

media studio
at the heart of the Cambridge Biomedical Campus

NHS
Cambridge University Hospitals
NHS Foundation Trust

Consent to Medical Photographic or Video Recordings

For staff use only:
Hospital number:
Surname:
First names:
Date of birth:
NHS no: _ _ _ / _ _ _ / _ _ _ _
Use hospital identification label

Note: Infection control
Patients who pose an infection risk should not be sent to Medical Photography. Please request a photographer to attend the ward/department and inform us of any infection controls that need to be observed (e.g. barrier nursing).

This form is part of the patient medical record.

Cambridge University Hospitals NHS Foundation Trust has adopted a policy in line with the General Data Protection Regulation which gives you the right to control the future use of photographs and video recordings taken of you during the course of your treatment. See https://www.cuh.nhs.uk/patient-privacy-notice

a ☐ Referral to Medical Photography:

I wish to refer you to Medical Photography for photographs/videos to be taken. These photographs or videos will be part of your medical records. With your consent, your images may also be used for teaching of medical, paramedical, nursing staff and UK medical students or for presentations at UK/international medical educational conferences.
In addition, your images may also be used for another specified use. For example, in a named medical journal or an on-line teaching resource.

b ☐ Medical Photography in the Trust by other staff:

I ..... confirm that I have registered with Medical Photography that the photography and the storage of the resulting images will take place in line with the Trust's Photographic Policy and Procedure, and I will take the appropriate photographs in a dignified manner, using equipment approved by Medical Photography.

Consultant (print) ..... Dept/Speciality: .....
Requesting Clinician (print) ..... Date: .....
Signature: .....

Consent form

In view of the explanation given to me by Prof/Dr/Mr/Miss/Mrs .....

* ☐ I consent to photographs / videos being taken for my personal medical records.

* ☐ I consent to photographs / videos of me being made available for teaching use as described in a above (you may change this consent later).

* ☐ I consent to photographs of me being used **for the specific purpose described below** (for example publishing use). This consent does not extend to any further publication(s) (once the photographs are published then this consent can not be withdrawn).

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* Please tick as relevant

Signature of patient/parent/guardian: ..... Date: .....

Relationship if not the patient: .....

Copy to be given to the Medical Photographer.
If the patient requires a copy, please print another or photocopy this form.

Please complete both sides of this form.

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Medical Photographic or Video Recordings Request Form

PLEASE WRITE CLEARLY & IN BLOCK CAPITALS

Date photography required: .....

Diagnosis: .....

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Any other instructions: .....

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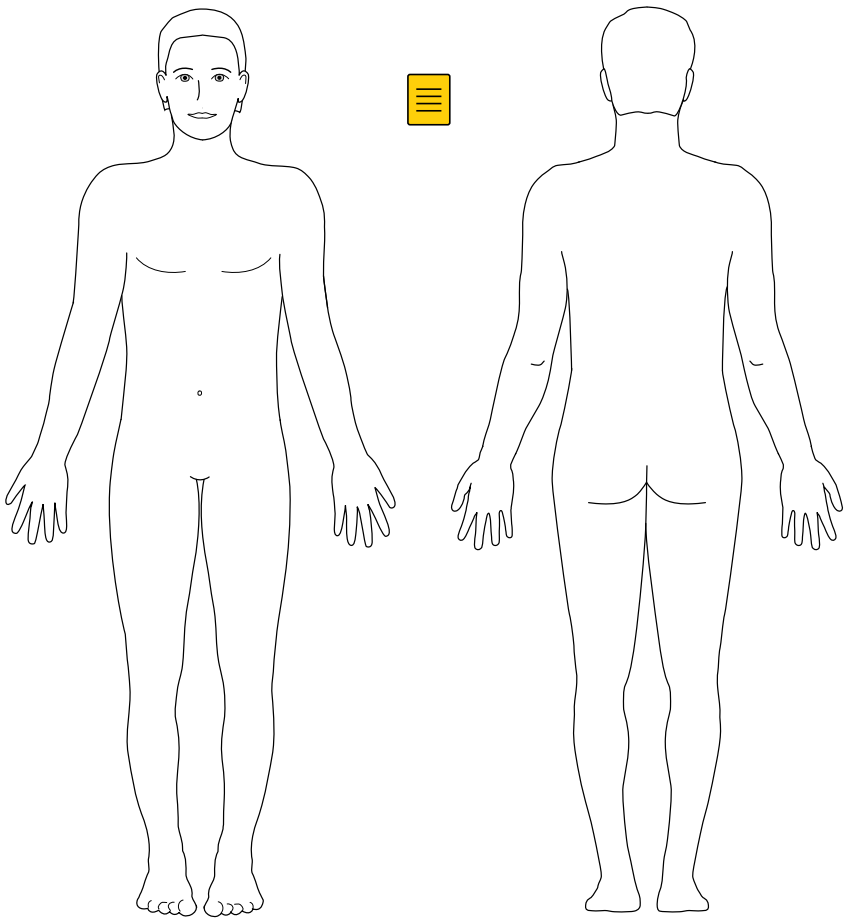

Dermatology

- ☐ Mole mapping
- ☐ Mohs views
- ☐ Dermoscope

Plastic surgery

- ☐ Abdominoplasty
- ☐ Browlift
- ☐ Facelift
- ☐ Facial palsy ☐ Palsy video
- ☐ Gynaecomastia
- ☐ Latissimus dorsi
- ☐ LeJour
- ☐ Standard breast views
- ☐ TRAM/DIEP

Oral/Maxillofacial

- ☐ Cleft views set 1
- ☐ Cleft views set 2
- ☐ Cleft views set 3
- ☐ Intra oral views
- ☐ Restorative dental views
- ☐ Routine orthodontic views

Ophthalmology

- ☐ 9 positions of gaze
- ☐ Ptosis
- ☐ Thyroid eye disease

ENT

- ☐ Pinnaplasty
- ☐ Rhinoplasty

Orthopaedics

- ☐ Scoliosis

Trial protocols

- ☐ BRT
- ☐ Columbus
- ☐ DIL frequency
- ☐ Fast forward
- ☐ FORUM
- ☐ GSK (MEK116513)
- ☐ Immunicore
- ☐ IMPORT High
- ☐ IMPORT Low
- ☐ Millenium
- ☐ Octave
- ☐ STEVIE

Other (please specify)

- ☐ .....

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Please complete both sides of this form.