Havering Therapy Centre
94 North Street
Hornchurch
RM11 1SR
Tel: 01708 621111
Email: admin@haveringtherapy.com
Web: www.haveringtherapy.co.uk

Registration Form (podiatry)

This document is for your safety, as well as our information. If you have any questions, please ask your clinician. Thank you for your co-operation. BLOCK CAPITALS PLEASE

Full name: (Mr/Mrs/Miss/Ms) …… Date of Birth: ……../……../……

Address:……

…… Post Code: ……

Contact Details:

Primary Phone: …… Secondary Phone: ……

Email address: ……

How did you hear about Havering Therapy Centre? ……

G.P. Details: (name) …… (practice) ……

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Certain medical conditions can affect podiatry treatment and vice versa, please indicate whether you have or have ever been diagnosed with the following:

Rheumatic fever
Any heart complaint (including heart murmur)
Diabetes
Epilepsy/Fits and fainting
Hepatitis
High Blood Pressure
Any other serious illness?
Are you allergic to any medicine or tablet?
(list below in notes)
Excessive bleeding or taking Warfarin/anti-coagulants

In the past 2 years have you been treated with hydro- cortisone or corticosteroids?
Please indicate or inform your podiatrist if you are HIV/Hepatitis B positive?
Did you receive growth hormone treatment before the mid-1980's?
Have you ever had a joint replacement operation?

In the past 2 years have you undergone any operations? ……

What is your average weekly consumption of alcohol? (units) ……

Please indicate whether you could be or are pregnant (circle): [n/a] [yes] [no]

Notes/Prescribed medications? ……

If you are not sure of any of the questions, or if your medical circumstances change, please inform your podiatrist

HAVERING THERAPY CENTRE established 1974

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Please use the back of the form to provide any further details if you have answered yes to any of the questions.

To the best of my knowledge these details are correct:

Signature: …… Name: …… Date: ……/……/……

BLOCK CAPITALS PLEASE

Consent Form

Full name: …… Date of Birth: ……

Address: …… Post Code: ……

Please ask your Podiatrist if you have any questions about your assessment or treatment.

( ) I consent to Podiatry assessment and treatment as deemed appropriate by the treating Podiatrist working on behalf of Havering Therapy Centre and I consent to the collection, use, and sharing of any relevant clinical information in providing this service to you.

( ) Throughout your episode of care with us, any questions or concerns you may have about any recommended treatment must be shared with your podiatrist immediately so they can explain the treatment rationale and/ or modify your program appropriately. If at any time you choose not to participate in the course of treatment, please tell your podiatrist immediately.

In order to safeguard patients and staff, Havering Therapy Centre have put in place strict infection control measures and protocols. This includes the use of Personal Protective Equipment and the cleaning of equipment and treatment facilities prior to your appointment.

( ) I agree to follow the instructions provided by the Government and clinic staff in order to reduce the risk of spreading the Covid 19 virus. I agree to not attend my appointment should I develop any symptoms of Covid19 prior to any of my appointment(s), including a prolonged cough, fever, or shortness of breath and notify Havering Therapy Centre on 01708 621111 (any cancellation charge in this instance will be waived).

( ) I agree to Havering Therapy Centre notifying me of appointment details via email.

Privacy Notice: We take your privacy very seriously and will take all necessary steps to protect your data and sensitive information. We comply with UK GDPR and the Data Protection Act 2018 (as amended by the Data (Use and Access) Act 2025), and all relevant medical confidentiality guidelines. Your confidential medical information will only be disclosed to those involved with your treatment. Further details can be found on our website: www.haveringtherapy.com

Your declaration and signature

By signing this form you confirm the following:

- I confirm I have read and understood the content of this consent form
- I consent to undertake an assessment and recommended treatment (if applicable) by a qualified Podiatrist registered with the Health and Care Professions Council.
- I consent to Havering Therapy Centre storing my personal and medical information, during my referral period and for as long after discharge, as is required by law
- I consent to my podiatrist sharing my personal data and medical information with my Insurance Company for the purpose of progressing my case (if applicable)

If you are not sure of any of the questions, or if your medical circumstances change, please inform your podiatrist

- I consent to Havering Therapy Centre sharing relevant personal & medical information with other clinicians, including my GP (if appropriate)
- I understand that I am responsible for the cost of my treatment(s) and agree to pay a cancellation fee (£30) if appointments are cancelled within 24 hours of the appointment time, or in the event of non-attendance the full fee.
- I am aware that the Podiatrist may use sharp instruments
- I understand that I may withdraw my consent at any time, without prejudice

Signature: …… Name: …… Date: ……..