Request for Retrospective Review Consent

To be completed by the Individual and/or representative requesting a retrospective review of CHC eligibility.

Patient's Name: ……

Patient's Date of Birth: …… …

Address: ……..

Telephone Number: ……

E-mail (if available): ……

Signature: …….. **Date**: ……..

If you are completing this form on behalf of the patient, you should ensure that you have authority to appeal on behalf of the person receiving care. This could be via a verbal agreement from the patient which has been recorded in their notes, written authority and, if applicable, legal authority e.g., original Enduring or Lasting Power of Attorney.

Certification / Consent	
Name:	
Relationship to the Individual:	
I certify that I have authority to act on behalf of the patient (Enclose a certified copy of relevant Power of Attorney*) ☐ Enduring Power of Attorney (prior to 1 October 2007) – if the person lacks capacity, it must be registered with the Office of the Public Guardian (OPG) ☐ Lasting Power of Attorney for Health and Welfare (post 1 October 2007) – registered with the OPG ☐ A best interest decision has been made with advocate/Independent Mental Capacity Advocate involvement (delete as appropriate)	
Signed:	
Date:	