

CYGNET GROUP ENROLMENT F O R M		
BASIC INFORMATION		
Date	How did hear about the Service	
Data Protection Consent		
Yes <input type="checkbox"/> No <input type="checkbox"/>		
INFORMATION ABOUT PARENTS/CARERS		
Parent or Carer		Relationship to child
Title		Gender
First name	Surname	Other name
Ethnicity	Religion	Preferred Language
Telephone Numbers		
Home:	Work:	Mobile:
Email:		
Parent or Carer		Relationship to child
Title		Gender
First name	Surname	Other name
Ethnicity	Religion	Preferred Language
Telephone numbers		
Home	Work	Mobile
Email:		
ADDRESS INFORMATION		
Address		
Post Code		

CHILD'S INFORMATION	
Name	Date of Birth
Diagnosis	Date of Diagnosis(if known)
By whom	Name of School
GP INFORMATION	
GP Surgery	Telephone Number
Address	
ADDITIONAL INFORMATION	

Please return this form to:
 ASD Pathway Co-ordinator
 NCHC NHS Trust
 Room 33
 St James
 Extons Road
 Kings Lynn PE30 5NU

Telephone 01553 668606 Email: AsdPathway@nchc.nhs.uk

	Cygnnet Programme
	Consent to receive service and agreement to record information. Form 1: for use by parents and carers (those with parental responsibility or delegated responsibilities) on behalf of their child.

Norfolk Community Health & Care/Children's Services has provided me with written information about the service and explained:

- what information they will collect, why and what they will use the information for;
- that the records may be kept in paper files or on electronic systems and may include photographs, videos and other personal information;
- my rights to access information recorded about my child;
- that information will be held in confidence, and the limits to confidentiality.

I agree to the above service(s) processing information about my child/the child I care for in order to provide the services.

I understand that I may review this consent at any time.

Name of child/young person receiving service:

Name of parent or carer:

Signature of parent or carer:

Date:

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