

## CD506 - Care Plan Consent Form

I understand that as an individual using the services at Inspiring Aspirations Plus Ltd T/A Inspiring Support this form provides authorisation for the Support staff to provide me with the care and support described and outlined in my Care Plan. I have contributed to the development of this plan and I confirm that the assessor from Inspiring Aspirations Plus Ltd T/A Inspiring Support has explained how I can contact Inspiring Aspirations Plus Ltd T/A Inspiring Support to discuss my care and support at any time.

I confirm/do not confirm **(delete as appropriate)** that I am happy for Inspiring Aspirations Plus Ltd T/A Inspiring Support to share information that is relevant to my care and support with other professionals involved in my care.

I confirm/do not confirm **(delete as appropriate)** that the Complaints Procedure has been explained to me and I have been given information on how to make a complaint.

I confirm that I require/do not require **(delete as appropriate)** assistance with medication and give/do not give **(delete as appropriate)** my consent for Inspiring Aspirations Plus Ltd T/A Inspiring Support to provide me with the assistance detailed in my Personalised Medication Plan.

<b>Name:</b>	
<b>Signed:</b>	
<b>Date:</b>	

**Representative Consent - To be completed by the representative if the individual is unable to give consent. Evidence that the representative has power of attorney must be seen.**

<b>Individual unable to sign due to:</b>	
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*I can confirm that I am authorised to consent to all the above on behalf of the individual named, in accordance with the individual best wishes and in line with the Mental Capacity Act 2005.*

<b>Name:</b>	
<b>Signed:</b>	
<b>Date:</b>	
<b>Relationship:</b>	

**This Care Plan was completed by:**

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<b>Name:</b>	
<b>Signed:</b>	
<b>Date:</b>	
<b>Role:</b>	

**Note: All QCS Policies are reviewed annually, more frequently, or as necessary.**