Diabetic RetinaScreen
An Clár Náisiúnta Scagthástála Reitiní do Dhiaibéitigh
The National Diabetic Retinal Screening Programme

Consent form

Consent to take part in Diabetic RetinaScreen

Diabetic RetinaScreen offers free, regular diabetic retinopathy screening to people with diabetes aged 12 and over. This information sheet explains why you need to give your consent to be part of the programme.

Data Protection in Diabetic RetinaScreen

The HSE, National Screening Service (NSS) is the data controller for the personal data you supply by participating in Diabetic RetinaScreen. The personal data will be stored securely and only processed in accordance with data protection law and the HSE's data protection policy.

With your consent we will process your data to ensure we can complete the screening test and invite you for any follow up treatment and future screening. You can withdraw this consent at any time and we will stop processing your information for these purposes.

We will also process your data in order to comply with our responsibilities as outlined in the Health Acts and other relevant legislation. This can include quality assurance, quality improvement, risk and claims management, patient experience; issuing reminders by SMS or email; and contacting people who might be suitable for research. Your data will not be used for research without consent. You can find out more about data protection rights and how to use them at www.hse.ie/gdpr.

Where will my information be stored?

It will be stored on the Diabetic Retinopathy Screening Register (DRSR). This is a secure database that lists the name, address, date of birth, mother's maiden name, PPSN and GP (family doctor) details of each person who takes part in Diabetic RetinaScreen. For confidentiality, each person on the database has a unique identification number, known as the Diabetic Retinopathy Screening ID (DRS ID).

How will my information be used?

Diabetic RetinaScreen will use your information to invite you for your free diabetic retinopathy screening test when it is due, to enable us to do this your information will be shared with our screening service providers. Your screening result letter will be sent to your GP and nominated endocrinologist. If follow up treatment is required we will share your information with your assigned treatment centre in order to invite you for treatment.

The image of your retina may be used in teaching. It may also be used in reviewing the photographer and graders to ensure the quality of the programme.

Your name will never be included in any reports, teaching or reviews. We will use your information to compile figures and reports to help us find out how well the programme is working.

Consent to the use of eye drops

As part of your diabetic retinopathy screening test, you will be asked to consent to the use of eye drops to dilate your pupils. The purpose and possible side effects of eye drops will be fully explained to you.

So that you are aware that:

- You may feel a stinging sensation (like getting soap in your eye) when the drops are first put in.
- Your sight may be blurry for up to 4 to 6 hours after the test.
- You should not drive until your vision returns to normal, which may be for up to 6 hours.
- Your eyes can feel sensitive to light after the drops have been used. Sunglasses may help.
- It may be difficult to read until your vision returns to normal.
- You should not rub your eyes after the drops are first used.
- You may not wear contact lenses for at least two hours after the eye drops have been used.
- Very rarely the use of eye drops may cause a condition called 'acute glaucoma'.

You will be given more information on what to do if this happens, in the attached advice sheet.

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Consent for Diabetic RetinaScreen – The National Diabetic Retinal Screening Programme

DRS ID	
Client name (please print)	
Date of birth (dd/mm/yyyy)	
Address	
Name of GP	
Name of Endocrinologist (if applicable)	
Name of Ophthalmologist (if applicable)	
Date of screening (dd/mm/yyyy)	
Photography and grading ID	

I have read and understand the information given to me.

I consent to:

A) Proceed with the screening test ☐

B) The use of eye drops ☐

Client's signature	Print name (BLOCK CAPITALS)	Date

For client's aged under 16 the signature of a parent or guardian must be provided

For office use only		
Tropicamide 0.5% administered today	Yes	No
Tropicamide 1% administered today	Yes	No
Phenylephrine 2.5% administered today	Yes	No

Photographer's signature	Print name (BLOCK CAPITALS)	Date