**Carers Identification And Consent Form**

Do you look after someone – a relative, friend or neighbour who is ill, frail or disabled and is unable to or has difficulty looking after themselves? Do you give support to someone with mental health needs or who misuses alcohol or drugs?

If you do, that means you are a carer and by registering with us as a carer could mean we are able to offer more support to you.

So that we may register you as a Carer, please complete this form and hand it to reception or post it to us.

**Your Details (the Carer):**

Surname:...................................... First Name(s): ...................................

Address: ...............................................................................................

.............................................................................................................

Date of Birth:………………………………………….

Landline No.: .................................... Mobile No: ...................................

Email address:.......................................................................................

Relationship to person cared for:………...................................………………………

I live with the person I care for**: Yes** **[ ]  No** **[ ]**

I am their next of kin: **Yes [ ]  No [ ]**

I am their emergency contact: **Yes [ ]  No [ ]**

I am the main carer: **Yes [ ]  No [ ]**

If you have a health problem, are you limited with the times you can see a doctor?  **Yes [ ]  No [ ]**

I give consent to being registered as a carer with this practice**:**

Signed:……………………………………………. Date:……………………………………………….

I give permission for Bedminster Family Practice to register my details, electronically, with the Carers Support Centre for advice and support.  **Yes** **[ ]  No** **[ ]**

**Details of the person who is cared for;**

*If the person for whom you care is also a patient at Bedminster Family Practice, please ask them to complete this section of the form;*

Surname:...................................... First Name(s): ...................................

Address: ...............................................................................................

.............................................................................................................

Date of Birth:……………………………………….

Home No. : .................................... Mobile No: ......................................

Email:............................................

Please ONLY tick the permissions you would like to give;

I give consent for my personal details (as above) to be recorded on my Carer’s clinical record  **Yes** [ ]  **No** [ ]

I give consent for my Carer’s details to be held on my medical records

 **Yes** [ ]  **No** [ ]

I give consent for my Carer to have access to ALL my medical records and personal details held by my GP Practice **Yes** [ ]  **No** [ ]

I give consent for my Carer to have access ONLY TO part of my records or relating to a specific condition only, as detailed below;

 **Yes** [ ]  **No** [ ]

*Please specify below precisely which part of your record or which condition you want your Carer to have access to;*

.............................................................................................................

............................................................................................................

I understand that a doctor may override this authority at any time and that this consent will remain in force until cancelled by me in writing

Signed: ................................................. Date: .....................

Accepted by: .......................................... (Doctor) Date: .....................

|  |  |  |  |
| --- | --- | --- | --- |
| Office Use Only: | Date | Actioned (Tick) | Initials |
| Carer Code(s) entered on EMIS;Carer (918A) & if applicable, Has a Carer (918F) |  |  |  |
| Carer(s) information added to EMIS |  |  |  |
| If Consent given, register with Carers Support Centre |  |  |  |
| Copy of form scanned to DOCMAN |  |  |  |