**CARERS IDENTIFICATION FORM**

**DO YOU LOOK AFTER SOMEONE WHO IS   
ILL, FRAIL, DISABLED OR MENTALLY ILL?**

If so, you are a Carer and we would like to support you. Please complete this form and hand it in to reception.

If you require support, you can contact Social Care Services (see Care Leaflet 1). A carer’s assessment is a chance to talk about your needs as a Carer and the possible ways help could be given. It can also look at the needs of the person you care for. This could be done separately, or together, depending on the situation. There is no charge for an assessment.

**YOUR DETAILS:**

|  |  |
| --- | --- |
| Name |  |
| Date of Birth |  |
| Address |  |
| Post Code |  |
| Telephone Number |  |
| Care You Provide |  |

**DETAILS OF THE PERSON YOU LOOK AFTER:**

|  |  |
| --- | --- |
| Name |  |
| Date of Birth |  |
| Address  (If Different From Above) |  |
| Post Code |  |
| Telephone Number |  |
| GP Details  (If Different From Your Own) |  |

***Thank you for completing this form***

**Appendix 3 – Form**

**AGREEMENT FOR A CARER TO HAVE ACCESS TO A PATIENT’S PERSONAL DETAILS and/or COPIES OF CORRESPONDENCE**

|  |  |
| --- | --- |
| Patient’s Name |  |
| Patient’s Address |  |

To: Petersfield Surgery

I give permission for my Carer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_to have access to my medical records and personal details held by the Practice.

This permission relates to all / part of my record / specific condition only (*delete as appropriate*).

Where the permission is restricted to part of the record only, please specify below the precise limits of this permission, and any areas of the record which are excluded.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that the doctor may override this authority at any time, and that this permission will remain in force until cancelled by me in writing.

I consent to my Carer receiving copies of all correspondence relating to my treatment (*delete if not applicable*). I confirm that this has been explained to me by my GP and that the GP has sole discretion to withhold all or any copies.

Signed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Patient)

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Accepted by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Doctor)

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Office Use Only:

|  |  |
| --- | --- |
| Copy Frequency |  |
| Specific Copy Exclusions |  |
| Specific Copy Inclusions |  |