**CARERS IDENTIFICATION FORM**

**DO YOU LOOK AFTER SOMEONE WHO HAS A PHYSICAL DISABILITY, LEARNING DISABILITY, DEMENTIA, MENTAL HEALTH, OR SUBSTANCE MISUSE PROBLEM OR MAY BE ILL OR FRAIL**

If so, you are a Carer and we would like to support you. Please complete and return this form to your GP Surgery

Book an Appointment with your GP, if your caring role is affecting your health.

**YOUR DETAILS**

|  |  |
| --- | --- |
| Name |  |
| Date of Birth |  |
| Address |  |
| Postcode |  |
| Telephone Number |  |
| Any Relevant Information |  |

**DETAILS OF THE PERSON YOU LOOK AFTER**

|  |  |
| --- | --- |
| Name |  |
| Date of Birth |  |
| Address (if different from above) |  |
| Postcode |  |
| Telephone Number (if different from above) |  |
| **GP Details (if different from above)** |  |

**AGREEMENT FOR A CARER TO HAVE ACCESS TO A PATIENTS PERSONAL DETAILS AND/OR COPIES OF CORRESPONDENCE**

|  |  |
| --- | --- |
| **Patients Name** |  |
| **Patients Address** |  |

**To: Oakmeadow Surgery**

I give permission form my Carer (name) 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 GP 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(GP) Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_