**We are here to support you in supporting others.**

## Carer’s identification form

By identifying yourself as a carer, we will be able to support you and signpost you to the support services available to you as a carer. If you consent, we will also refer you to Adult Social Care for an assessment; they will identify your needs and provide further support to you as a carer.

|  |
| --- |
| **Carer’s details:** |

|  |  |  |  |
| --- | --- | --- | --- |
| **Surname** |  | **Forename** |  |
| **Date of birth** |  | **NHS number** |  |
| **Street** |  | **Region** |  |
| **Town or city** |  | **Postcode** |  |
| **Telephone** |  | **Email** |  |

|  |
| --- |
| **Details about the person you care for:** |

|  |  |  |  |
| --- | --- | --- | --- |
| **Surname** |  | **Forename** |  |
| **Date of birth** |  | **NHS number** |  |
| **Street** |  | **Region** |  |
| **Town or city** |  | **Postcode** |  |
| **Telephone** |  | **GP & practice**  |  |

|  |
| --- |
| **Details about the care you provide:** |
|  |

|  |  |
| --- | --- |
| **I consent to you referring me to Adult Social Care for an assessment.** |  |
| **Please pass my details to the local carer support services.** |  |

|  |  |
| --- | --- |
| **Signature** |  |
| **Date** |  |

**Please return completed forms to reception.**

## Carer-patient consent form

|  |
| --- |
| **Patient details:** |

|  |  |  |  |
| --- | --- | --- | --- |
| **Surname** |  | **Forename** |  |
| **Date of birth** |  | **NHS number** |  |
| **Street** |  | **Region** |  |
| **Town or city** |  | **Postcode** |  |
| **Telephone** |  | **GP details** |  |

|  |
| --- |
| **Carer details:** |

|  |  |  |  |
| --- | --- | --- | --- |
| **Surname** |  | **Forename** |  |
| **Date of birth** |  | **NHS number** |  |
| **Street** |  | **Region** |  |
| **Town or city** |  | **Postcode** |  |
| **Telephone** |  | **GP & practice**  |  |

I give permission for my named carer to have access to my healthcare records held by my GP surgery. This permission relates to all / part of my record\*. *(\*Please delete as appropriate.)*

Where permission is restricted to part of the record, please stipulate those areas for which access is authorised:

**I am aware that my GP may overrule my decision at any time and that this authorisation will remain in force until ……/……/…… or until cancelled by me (in writing).**

|  |  |
| --- | --- |
| **Signature (of patient)** |  |
| **Date** |  |

**I agree that I will treat all information confidentially and will not disclose this information to any third party without the express permission of the person named as the patient above. I will only use this information in the best interests of the patient.**

|  |  |
| --- | --- |
| **Signature (of carer)** |  |
| **Date** |  |