

# SIDCUP MEDICAL CENTRE

## CARER

### 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 who has mental health needs or misuses alcohol or drugs?

If you are, that means you are a Carer and by registering that you are a Carer with the Practice it could mean that we are able to offer you more support.

**PLEASE COMPLETE THIS FORM AND HAND IT TO RECEPTION, OR POST IT TO US.**

<b>YOUR DETAILS:</b>				
Surname:.....		Forename:.....		
Date of Birth: .....				
Address:.....				
.....				
..... Post Code:.....				
Home No:.....		Mobile No:.....		
Email:.....				
Relationship to person cared for :.....				
I live with the person I care for:	<b>Yes</b>	<input type="checkbox"/>	<b>No</b>	<input type="checkbox"/>
I am their next of kin:	<b>Yes</b>	<input type="checkbox"/>	<b>No</b>	<input type="checkbox"/>
I am their emergency contact:	<b>Yes</b>	<input type="checkbox"/>	<b>No</b>	<input type="checkbox"/>
I am the main carer:	<b>Yes</b>	<input type="checkbox"/>	<b>No</b>	<input type="checkbox"/>
I give consent to being registered as a Carer with this practice:				
Signed:.....		Date:.....		

I give permission for my details to be passed to the Carers' Support (Bexley) for advice and support.	<b>Yes</b>	<input type="checkbox"/>	<b>No</b>	<input type="checkbox"/>
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**Practice Administrative Staff Only:**  
If the Carer has agreed for the information to be sent to Carers' Support (Bexley) please scan and email to: [carerssupport@nhs.net](mailto:carerssupport@nhs.net) or post to: Carers' Support (Bexley), the Manor House, Grassington Road, Sidcup, Kent, DA14 6BY.

**SIDCUP MEDICAL CENTRE**

**CARER**

**IDENTIFICATION AND CONSENT FORM**

Carer's Name: .....

**DETAILS OF PERSON CARED FOR:**

Surname:..... Forename:.....

Date of Birth: .....

Address:.....

.....

.....

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

Email:.....

I give consent for the above information about me to be recorded on the clinical record of the person who cares for me.

I give consent for the details of my Carer to be held on my medical records.

I also give consent for relevant medical information to be shared with my Carer.

Signed:.....

Date:.....