Carer's identification and referral form
Thistlemoor Medical Centre

Appendix 1 - Form

Do you look after someone with long term illness, is frail, disabled or mentally ill?

If so, you are a carer and we would like to support you. Please complete this form and return it to us electronically and send by email or hand it in to reception.

If you are agreeable, we will pass your details to the Carers Service, which is a countywide organisation providing relevant information and advice, local support services, newsletter and telephone link line for carers.

We will also refer you, with your permission, to have your needs assessed by Adult Care Services. A Carers 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	
Any relevant information	

Details of the person you look after:

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

☐ Please pass my details to the Carers Service.

☐ Please refer me to Adult Care Services for a Carers Assessment.

Thank you for completing this form

Appendix 2 – Letter

Thistlemoor Medical Centre

Letter to patients

[date]

Dear [patient's name]

Carers

Do you look after someone who is ill, frail, disabled or mentally ill? If so, you are a carer. We are interested in identifying carers, especially those people who may be caring without help or support. We know that carers are often "hidden" looking after a family member or helping a friend or neighbour with day to day tasks and may not see themselves as a carer.

We feel that caring for someone is an important and valuable role in the community, which is often a 24-hour job that can be very demanding and isolating for the carer. We further believe carers should receive appropriate support by way of access to accurate information on a range of topics such as entitlement to benefits and respite care and not least, a listening ear when things get too much.

As a Carer, you are also entitled to have your needs assessed by Adult Care Services. A Carer's Assessment is a chance to talk about your needs as a carer and the possible ways help could be given. It also looks 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.

If you are a carer, this is an opportunity to let the Practice now so that we can update our records and pass on your details to the Carers Service who can provide relevant information and advice, local support services, newsletter and telephone linkline. We can also refer you to Adult Care Services for a carer's assessment.

Please complete the attached sheet only if you are a carer and return it to the surgery.

We look forward to hearing from you.

Yours sincerely

Dr Neil Modha

Appendix 4 – 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: *[Insert Practice name]*
I give permission for my Carer [*Insert 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 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	