Leamore Medical Practice

CARERS DETAILS

If you are a carer or have a carer
Please complete this form and return it to reception.

Information about the carer			
Name of your GP Surgery			
Full Name			
Address Inc. Postcode			
Date of Birth			
Phone number/s		Email	
Relationship to the patient			
Are you their Next of Kin?	YES/NO	If No – Who is?	
Are you the emergency contact?	YES/NO	Do we have permission to discuss their care history/record with you? YES/NO	
If No, you will need to gain consent from the patient to do this and fill in the third party consent form part at the end of this document.			
Information about the person they care for:			
Name of their GP Surgery			
Full Name			
Address Inc. Postcode			
Date of birth			
Phone number/s			

SUPPORT

What kind of support might you need? (Tick as many boxes as apply):

INFORMATION/ADVICE ☐

PREVENT ADMISSION TO HOSPITAL/RESIDENTIAL CARE ☐

BREAK FROM CARING ☐

OTHER ☐
Please provide brief details:

During the last month have you been bothered by feeling down, depressed or hopeless?

YES / NO

During the last month, have you been bothered by having little interest or pleasure in doing things?

YES / NO

If you answered yes to any of the questions above, would you like to receive information and/or support regarding this?

YES / NO

SIGNED BY PATIENT / CARER	DATE:

Leamore Medical Practice

Patient Third-Party Consent Form

Patient Name:	
Telephone No:	
Address:	
Consent given to… **Name:**	
Telephone No:	
Address:	

If you are making an enquiry on behalf of a patient, or your enquiry involves the medical care of a patient, then the consent of the patient will be required.

Please obtain the patient's signed consent below:

I (Insert Name) ……..
Fully consent to my doctor releasing information to the above named and to discuss my care and medical records with this person.

This authority is for an indefinite period / for a limited period only (delete as appropriate).

Where a limited period applies, this authority is valid until (insert date)……………………………………………

Signed (Patient): ……….

Print Name: ……..

Date: …….

Please ensure the form has been signed by the Patient
and return it to Varindra Panchhi – Practice Manager at the Practice.