

# Oaklands Medical Centre

## 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:

<b>Surname</b>		<b>Forename</b>	
<b>Date of birth</b>		<b>NHS number</b>	
<b>Street</b>		<b>Region</b>	
<b>Town or city</b>		<b>Postcode</b>	
<b>Telephone</b>		<b>Email</b>	

### Details about the person you care for:

<b>Surname</b>		<b>Forename</b>	
<b>Date of birth</b>		<b>NHS number</b>	
<b>Street</b>		<b>Region</b>	
<b>Town or city</b>		<b>Postcode</b>	
<b>Telephone</b>		<b>GP &amp; practice</b>	

### Details about the care you provide:

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Please pass my details to the local carer support services.

<b>Signature</b>	
<b>Date</b>	

Please return completed forms to the reception at Oaklands Medical Centre

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## 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	

**Please return completed forms to the reception at Oaklands Medical Centre**