LONG BENINGTON MEDICAL CENTRE

Am I an unpaid Carer?

Do you help a family member, friend or neighbour that:

- Has a disability
- Has a mental illness
- Has a chronic illness
- Is frail
- Has a substance misuse problem with alcohol or drugs

Please tick as many of the statements below that you think apply to you

Is the help you provide, regular and on-going? ❑

Does this help involve showering, toileting, dressing or other personal care? ❑

Does this help involve cleaning, cooking, shopping, transport and/or assistance with bills or other paperwork? ❑

Does this help involve medication or other healthcare? ❑

Would this person have difficulty managing on their own if you could not provide regular and on-going support? ❑

Do you receive Carers Allowance or no payment at all? ❑

If you can tick any of the above - you are a carer.

In order for us to help provide you with relevant information please complete the form overleaf……

YOUR DETALS

Name ……Date of birth……

Address …….

…….

…….

Telephone Number ……..Mobile NO ……..

Preferred contact number Landline ❑ Mobile ❑

Would you like to receive text messages/reminders from us? Yes ❑ No ❑

Would you like to have online access to book appointments or order repeat medication?

Yes ❑ No ❑

Email address …….

I give consent to be added to the Carers Register at Long Bennington Medical Centre and for the Practice to contact me about the patient named, as necessary. I also consent for this information to be shared with other professional care agencies, including the General Practice of the person I care for. It has been explained to me how this information is to be used. I understand that I may withdraw/alter my consent at any time by advising the General Practice of the person I am caring for and my own General Practice. ❑

I consent to my name being added to the Cared for person's patient record Yes ❑ No ❑

Signature……Date……..

I have received a Carers Information Pack from my Practice ❑

I would like someone from the Lincolnshire Carers Service to contact me ❑

I would like to contact the Lincolnshire Carers Service myself ❑

Details of the Person being cared for (OPTIONAL)

Name ……..Date of Birth……

*Address……..

……

……

*GP Practice ……..

Relationship to the Carer ……

Health Condition (S)……..

……

……

***IF DIFFERENT FROM CARER**

OPTIONAL CONSENT FROM THE PERSON BEING CARED FOR

I consent to my named Carer being recorded on my medical records Yes ❑ No ❑

I consent to information about my health being discussed with the person named on this form as my carer when appropriate and I agree that this information can be shared with other professional care agencies. I understand why this information is being collected and how it will be used and I also understand that I can withdraw/ alter this consent at any time. Yes ❑ No ❑

I consent that this person may request/and or collect my repeat prescriptions and test results Yes ❑ No ❑

Signature……..Date……..

***PLEASE DELETE IF CONSENT IS NOT GIVEN

If you do wish us to refer you to the Lincolnshire Carers Service we will require some basic details about you and the person being cared for before contacting them. The details they will need are: Name, address and Date of Birth for both the Carer and the person being Cared for. Brief details about the Cared for person's condition(s), a brief description of what the Carer does for the Cared for person and if there is anything in particular they feel they are struggling with. They would also like to know if the Carer would like to have a Carer's Assessment. This will then enable them to signpost you to the appropriate area of the Service.

For GP staff use only

Carers Information Pack given to Carer:	Yes ❑ No ❑
Carer added to Carers Register:	Date……..
Carer referred to Lincolnshire Carers Service	Date……..
Text/email/Communications standards completed:	Date……..
Online access account created if requested:	Date……..