Linden Medical Group

Carers Identification and Referral 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 Northamptonshire Carers Service for an assessment, who will identify your needs and provide further support to you as a carer.

Carers details:	
Name	
Date of Birth	
Address	
Post Code	
Home Phone	
Mobile Phone	
Email	
GP Practice where you are registered	
Signature :	Date:

Details about the person you care for:	
Name	
Date of Birth	
Address & Postcode (If different from above)	
Contact Telephone No (If different from above)	
Relationship to Carer	
GP practice where the person you care for is registered	

Details about the care you provide:

I consent to you referring me to *Northamptonshire Carers Service for further information and support	

*The Northamptonshire Carer's Service is a countrywide organisation offering support to carers and young carers by providing useful information, support and advice such as Free Carers sitting service and free gym sessions

Please return completed forms to reception.

Linden Medical Group

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 details**	

I give permission for my named carer, to have access to my healthcare records held by my GP surgery. (Details below)

Please tick which option is applicable below:

This permission relates to all my records.	

The permission relates to part of my records.	
Please specify the parts of the record to which access is allowed and any areas which are specifically excluded.	

This permission relates to a specific condition.	
Please specify the condition.	

I understand that this permission will remain in force until cancelled by me in writing and that the doctor may override this authority at any time.
By signing below I consent to the above information being recorded on my medical record.

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 form to reception.