**Adult Carer’s Registration Form**

**Do you provide unpaid care and support to a family member, friend or neighbour who is ill, frail, disabled or has mental health or substance misuse problems? If so you are a Carer and we would like to support you. Please fill in this form and hand into reception.**

**About me: The Carer**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Name |  | | | | |  |
| Date of Birth |  | | | | |  |
| Address |  | | | | |  |
| Post Code |  | | | | |  |
| Telephone Number | Home | | | Mobile | |  |
| Can we contact you by email? | Yes/No | Email Address: | | | |  |
| Any Relevant Information |  | | | | |  |
|  |
| How many hours per week are you caring? | 1-10 hours | |  | 10-20 hours |  |  |
|  | 20-30 hours | |  | 40 hours + |  |  |
|  | Full- Time 24/7 | |  |  |  |  |
| Do you work alongside your caring role? | Full-Time | |  | Part-Time |  |  |
|  | Self-Employed | |  | Voluntary Work |  |  |
| Is your employer aware that you are a carer? | Yes | |  | No |  |  |
|  | Not Employed | |  | Retired |  |  |
|  |  | |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Please tick below as necessary, so that we can provide you with the best help and support. |  |  | |  |
|  |  |  | |  |
| I have already had a carer’s assessment. (If so, please tell us the date of your assessment) | | |  | |
| I would like to be referred to Care for the Carers for information, advice and support | | |  | |
| I would like to receive more information about help and support from the carers lead at the Practice. | | |  | |
| Are you aware of your rights as a carer? | | |  | |

I give consent for my details to be held by my surgery and for them to contact me about the patient named below. YES/NO

I am a Carer and I would like my caring role to be recorded on the Practice Carers Register.

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**About the Person that I care for**

|  |  |  |
| --- | --- | --- |
| Name |  | |
| Date of Birth |  | |
| Address (If different from above) |  | |
| Post Code |  | |
| Telephone Number (If Different from Above) | Home | Mobile |
| GP Details (If Different from your Own GP) |  | |
| Relationship to yourself |  | |

I hereby consent for my carer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to speak to the practice on my behalf. I am aware this will allow the carer to have full access to my medical records.

Signed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_