Billericay Medical Practice
Stock Road, Billericay, Essex CM12 0BJ

CARERS FORM

DO YOU LOOK AFTER SOMEONE WHO COULD NOT MANAGE WITHOUT YOU?

Many people look after friends or relations who need support due to frailty, disability or a serious health condition, mental ill health or substance misuse. Often, people do not think about how the person reliant on them will access their medical needs if they reach a point where they rely on someone else to do this for them. That is why we need to know who you are and get their permission for you to act on their behalf. If you require further information regarding being a carer then please check our website www.gps-billericayhealthcentre.co.uk or phone the Care Navigator Partnership on 0300 303 9988.

Please take a moment to complete the form below and ask the person you are caring for to sign their consent that you can act on their behalf. We can then confirm this with the person concerned and register you on their medical record as their carer.

When you return the form to us, please bring along some photographic identification of yourself.

THE PERSON YOU ARE CARING FOR:

Full Name	
Date of Birth	
Address	
Home Telephone Number	
Mobile Number	
Are you registered at this surgery?	Yes/No
Do you have a Power of Attorney (Health) in Place?	Yes/No *Please cross out the option not applicable, if yes please bring the original into surgery to copy and code*
If yes, please write the name of your Power of Attorney (Health) representative(s) here	
Please give their contact details here	
Please give a brief description of your needs for a carer i.e. your conditions such as COPD, Heart Failure, Frail, Physical or sensory impairment, etc	

Please sign the box here that you give consent for the person detailed overleaf to act on your behalf on all medical matters and that you consent to the disclosure of any of your medical information to them. By signing this you consent to access to any sensitive information that may be contained in your medical records	**Third Party Consent** Signed …….. Dated ……

FOR COMPLETION BY THE CARER:

Full Name	
Date of Birth	
Address	
Home Telephone Number	
Mobile Number	
Are you a patient registered at this surgery	Yes/No

Statement:

I ……(Please sign), do hereby confirm that I am caring for the person named overleaf and understand that I can act on their behalf in cases of medical need with the GP Surgery.

I have provided photographic identification to the Practice.

(If you do not have photographic identification, please provide a current utilities bill or bank statement, no older than 3 months)

Please confirm whether you are in receipt of a Carers Allowance Yes/No

Change in circumstance: Carers responsibility

The person receiving care may or may not be registered at Billericay Medical Practice.

When this situation arises, because the Practice will not be always be able to ascertain that the Carer / Patient relationship has ceased it will be the carers responsibility to contact the surgery to notify us of the change in circumstances.