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| PRACTICE  **SELDEN MEDICAL CENTRE**  **6 Selden Road, Worthing, BN11 2LL**  **Telephone Number: 01903 234962** |

CARERS REGISTRATION FORM

If you care for, or help, someone with an illness, physical disability or mental health difficulty, whether this is a partner, friend, relative or neighbour, then you are a CARER.

The practice holds a register of all our patients who are caring for others. This register will help us to acknowledge you and your needs as a carer and provide you with further information where appropriate.

In order to help us we would be grateful if you would fill in the information requested below, sign and hand this form in at the reception desk.

# Your details

Name …………………………………………. …………………D.O.B ………………..

Address …………………………………………………………………………………….

……………………………………………………………………………………………….

Telephone number…………………………………………………………………………

Your ethnicity e.g. White British, Black African…………………………………………

I give consent to be added to the Carers Register at Selden Medical Centre.

Signature………………………………………………………….Date………………….

Please tick this box if you are sending the form electronically to confirm that you have read and understood the above declaration and that it applies to you.

**\*\*** Please sign and date below if you would like to be added to the Carers Support Service database in order to receive regular carers’ information by post including their quarterly Carers News Sheet.

Signature………………………………………………………….Date………………….

Please tick this box if you are sending the form electronically to confirm that you have read and understood the above declaration and that it applies to you.

**\*\*** Please sign and date below if you would like a support worker from the Carers Support Service to contact you.

Signature …………………………………………………………Date…………………….

Please tick this box if you are sending the form electronically to confirm that you have read and understood the above declaration and that it applies to you.

**Carers who provide *regular and substantial* care are legally entitled to a Carers Assessment.**

**\*\*** Please sign and date below if you would like to be referred to Social Services for an assessment of your caring situation (Carers Assessment).

Signature………………………………………………………….Date……………………

Please tick this box if you are sending the form electronically to confirm that you have read and understood the above declaration and that it applies to you.

# Details of the person cared for

Name …………………………………………………………………………………………

Date of birth ……………………………………………………………...………………….

Relationship to the carer ……………………………………………….………………….

Their illness or disability ………………………………………………..………………….

……………………………………………………………………………..………………….

**Optional consent from the person cared for**

I agree to information about my health being discussed with the person named on this form as my carer. I hereby consent to my named carer being recorded on my medical records and that this person may request and/or collect my repeat prescriptions.

Signature………………………………………………………….Date……………………

Please tick this box if you are sending the form electronically to confirm that you have read and understood the above declaration and that it applies to you.

**For GP staff use only:**

Carers Information Pack given to carer yes / no

Carers Support Service leaflet given to carer yes / no

Carer added to Carers Register date ………………………...

Carer referred to Carers Support Service date …………...…………....

West Sussex Contact Assessment Form sent to

Social Services date ………………………....