

Your Doctor's Surgery Need to Know If You Look After Someone

Carer Registration and Referral

CISS REFERENCE NUMBER:

If you are a child or adult who helps to support a relative, partner, friend or neighbour who is ill, frail, disabled or who has mental health or alcohol and drug problems, YOU ARE A CARER.

Please complete this form and hand it, or send it to your GP's Surgery, who will record in your notes that you are a carer. This can help your surgery provide you with help with: arranging repeat prescriptions, flu immunisation, annual health checks and arranging appointments which fit in with caring.

Tell us what information and support you want by ticking the boxes below and overleaf. For help to complete this form please contact Carers' Information and Support Service on: 01482 336297/8 or ask at your surgery.

Carer

First Name (s) _____ Title (Mr/Mrs/Ms) _____

Last Name _____ Date of Birth _____

Address _____

Ethnicity _____

Day Time Number _____ Evening Number _____

Mobile Number _____

Email _____ When is it best to contact you? _____

Your relationship to the person cared for: Spouse Partner Relative Friend Neighbour

Name of GP _____ G.P. Practice Name _____

GP Practice Address _____

Carer Consent

	✓ Yes	✓ No
I give my consent to be added to the carers register at my GP Surgery	<input type="checkbox"/>	<input type="checkbox"/>
Carers who provide regular and substantial care are legally entitled to a Carer Assessment I would like to be referred for a Social Services Carer Assessment of Needs	<input type="checkbox"/>	<input type="checkbox"/>
I would like to be added to the Carers Information and Support Service (CISS) data base in order to receive a regular carer's newsletter	<input type="checkbox"/>	<input type="checkbox"/>
I would like a follow-up call from a Carer Support Worker from CISS	<input type="checkbox"/>	<input type="checkbox"/>
I would like an appointment to see a carer support worker at the surgery	<input type="checkbox"/>	<input type="checkbox"/>
I have difficulty understanding written information and need help	<input type="checkbox"/>	<input type="checkbox"/>
I would like to receive any information via email	<input type="checkbox"/>	<input type="checkbox"/>

I understand that a copy of this form will be held securely at the CISS under the Data Protection Act 1998

Signature..... Date.....

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Carer

<input type="checkbox"/> Access to training and employment support for carers	<input checked="" type="checkbox"/> Emotional support	<input checked="" type="checkbox"/> Support from your GP and Primary Care Team	<input checked="" type="checkbox"/>
<input type="checkbox"/> Juggling caring and working	<input type="checkbox"/> Direct Payments	<input type="checkbox"/> DVD about caring skills	<input type="checkbox"/>
<input type="checkbox"/> Carer Assessments	<input type="checkbox"/> Adapting your home	<input type="checkbox"/> Carer support groups	<input type="checkbox"/>
<input type="checkbox"/> Information about the illness	<input type="checkbox"/> Aids and Equipment	<input type="checkbox"/> Lifting and handling safely	<input type="checkbox"/>
<input type="checkbox"/> Medication management	<input type="checkbox"/> Residential & nursing homes	<input type="checkbox"/> Emergency care cover for 'carers'	<input type="checkbox"/>
<input type="checkbox"/> Support for young carers	<input type="checkbox"/> Telecare	<input type="checkbox"/> Support when caring for someone affected by mental health	<input type="checkbox"/>
<input type="checkbox"/> Welfare Benefits	<input type="checkbox"/> Chemist	<input type="checkbox"/> Other (Please describe)	<input type="checkbox"/>

Person Cared For – Optional Consent

I consent to information about my health being discussed with the person named on this form as my carer. I consent to my named carer being recorded on my medical records and that this person may request and/or collect my repeat prescriptions and test results. I will contact the practice if this information changes.

First Name(s)	Title	Date of Birth
Last Name		
Address		
Day Time Number	Evening Number	
Mobile Number	When is best to contact you?	
Email		
Please briefly describe illness or disability		
Signature.....		Date.....

GP Staff Use Only

	Date	Name (Please print)
Carer Read Coded: Carer 918A /Has a carer 918F/Carer's Details 9180		
Registration form sent to appropriate surgery when carer not a patient of this practice		
Registration Faxed/sent to Carers Support and Information Service (CISS) 3rd Floor, Wilberforce Health Centre Centre, Story Street, Hull, HU1 3SA Fax 01482 - 336386		
Carer informed who is the Carer Link in the Surgery		

CISS Staff Use Only

	Date	Name (Please print)
Carer Registered on Data Base/information sent		
Carer Received Follow-Up Call		
Outreach appointment confirmed		
Referred for a Carer Assessment		