**FARLEY ROAD MEDICAL PRACTICE**

**CARERS PACK**

**Do you look after someone who could not manage without you?**

**You may be a carer….**

If you provide help and support to a partner, relative, child, friend or neighbour who could not manage without your help due to physical or mental illness, a disability, frailty or addiction.

Anyone can become a carer. Many people don’t think of themselves as carers, they just look after someone close to them. Caring often just happens to you, as you find someone close to you gradually needs more help.

**Support for you**

As a carer it is important that you look after your own health too. We will do our best to help you look after yourself. We keep a register of Carers who are our patients so that can let you know about support, usually via email or letter and you will also be offered a free flu vaccination each year.

If you have not already done so, please fill out the attached form to register as a Carer at the surgery. There is also a form that can be filled out by the person you are caring for to allow you access to medical records. Without this form of consent, we will not be able to discuss with you the medical records of the person you care for.

**How can the Practice Support You**

* We will offer you a free flu vaccination
* We can inform you of local events or information specifically for Carers.
* We will offer support at any time that you need it

**How to contact the surgery**

If you are concerned about the person you care for or yourself and are registered at our practice you can call us on 02086511222 and ask to speak with a doctor. You can also email us any concerns you may have on admin@farleymedical.info.

**Useful contact numbers**

**Carers Line 0808 808 7777**

[**www.carersuk.org**](http://www.carersuk.org)

**Princess Royal Trust for Carers 020 7480 7788**

[**www.carers.org**](http://www.carers.org)

**Community Nursing Service 020 8714 2950/ 020 8274 6195**

**Occupational Therapy 020 8401 3121 CUH**

 **020 8726 6500 COMMUNITY**

**Falls Prevention Service 020 8401 3973 CUH**

 **020 8274 6258 COMMUNITY**

**Ch-tr.FallsReferrals@nhs.net**

**Social Services 020 8726 6000**

**Red Cross Home Care Services 020 8688 6895**

**Woman’s Royal Voluntary Service 0845 608 0122**

**(WRVS)**

**Local Carers Organisation** [**www.carersuk.org**](http://www.carersuk.org)

**Community Matron 020 8714 2956**

**Respite Providers** [**www.croydon.gov.uk**](http://www.croydon.gov.uk)

**Local Carer Charities** [**www.carersuk.org**](http://www.carersuk.org)

**Source of Carer Literature for Display www.carersuk.org**

# CARERS IDENTIFICATION AND REFERRAL FORM

**DO YOU LOOK AFTER SOMEONE WHO IS
ILL, FRAIL, DISABLED OR HAS A MENTAL HEALTH CONDITION?**

If so, you are a carer and we would like to support you.

Please complete this form and hand it in to reception.

# YOUR DETAILS:

|  |  |
| --- | --- |
| Name |  |
| Date of Birth |  |
| Address |  |
| Post Code |  |
| Telephone Number |  |
| E-mail address |  |
| Care You Provide |  |

**DETAILS OF THE PERSON YOU LOOK AFTER:**

|  |  |
| --- | --- |
| Name |  |
| Date of Birth |  |
| Address (If Different From Above) |  |
| Post Code |  |
| Telephone Number  |  |
| E-mail address |  |
| GP Details (If Different From Your Own) |  |

***Thank you for completing this form***

**AGREEMENT FOR A CARER TO HAVE ACCESS TO A PATIENT’S
PERSONAL DETAILS and/or COPIES OF CORRESPONDENCE**

|  |  |
| --- | --- |
| Patient’s Name |  |
| Patient’s Address |  |

To: Farley Road Medical Practice

I give permission for my carer ……………………… to have access to my medical records and personal details held by the practice.

This permission relates to all / part of my record / specific condition only (*delete as appropriate*).

Where the permission is restricted to part of the record only, please specify below the precise limits of this permission, and any areas of the record which are excluded:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that the doctor may override this authority at any time, and that this permission will remain in force until cancelled by me in writing.

I do/do not consent to my carer receiving copies of all correspondence relating to my treatment (*delete if not applicable*). I confirm that this has been explained to me by my GP and that the GP has sole discretion to withhold all or any copies.

Signed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Patient) Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Accepted by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Doctor) Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Office Use Only:

|  |  |
| --- | --- |
| Copy Frequency  |  |
| Specific Copy Exclusions |  |
| Specific Copy Inclusions |  |