Solihull Healthcare Partnership- we need to know if you look after someone

Carer Registration and Referral – complete form and email to nhsbsolicb.shpcarersteam@nhs.net or hand in to one of our front desk staff.

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 Trust Solihull Support Service on: 0121 788 1143 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: Solihull Healthcare Partnership

GP Practice Address: 3 Grove Rd, Solihull B91 2AG

 **Carer Consent 🗸Yes 🗸No**

|  |  |  |
| --- | --- | --- |
| I give my consent to be added to the carers register at my GP Surgery | □ | □ |
| Carers who provide regular and substantial care are legally entitled to a Carer AssessmentI would like to be referred for a Carer Assessment of Needs | □ | □ |
| I would like to be added to the <https://solihullcarers.org/> data base inorder to receive a regular carer’s newsletter | □ | □ |
| I would like a follow-up call from a Carer Support Worker from <https://solihullcarers.org/>  | □ | □ |
| I would like an appointment to see a carer support worker at the surgery | □ | □ |
| I have difficulty understanding written information and need help | □ | □ |
| I would like to receive any information via email | □ | □ |

I understand that a copy of this form will be held securely at the <https://solihullcarers.org/> under the Data Protection Act 1998
**Signature…………………………………......………………… Date……………....……..…..**

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# Carer 🗸 🗸 🗸

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Access to training and employment support for carers | □ | Emotional support | □ | Support from your GP and Primary Care Team | □ |
| Juggling caring and working | □ | Direct Payments | □ | DVD about caring skills | □ |
| Carer Assessments | □ | Adapting your home | □ | Carer support groups | □ |
| Information about the illness | □ | Aids and Equipment | □ | Lifting and handling safely | □ |
| Medication management | □ | Residential & nursing homes | □ | Emergency care cover for ‘carers’ | □ |
| Support for young carers | □ | Telecare | □ | Support when caring for someone affected by mental health | □ |
| Welfare Benefits | □ | Chemist | □ | Other (Please describe)………………………………………….. | □ |

**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 |
| Last Name Date of Birth |
| Address |
| Day Time Number Evening Number |
| Mobile Number |
| Email When is best to contact you? |
| Please briefly describe illness or disability |
|  |
| **Signature……………………………………..…………...........…..……… Date…………………** |

FOR SHP Staff:

1. Read code via EMIS clinical system
2. Send form to <https://solihullcarers.org/> and upload to patient or carer record.