THE THREE SHIRES MEDICAL PRACTICE

Colerne, Marshfield, Pucklechurch and Wick Surgeries

Dr Richard Greenway
Dr Richard Prince
Dr Pedro Pinto
Dr Keira Prince
Dr Dana Parr

Colerne Surgery	Tel: (01225) 742028
Marshfield Surgery	Tel: (01225) 891265
Pucklechurch Surgery	Tel: (0117) 937 2350
Wick Surgery	Tel: (0117) 937 2214

Do you look after someone who is ill, frail, disabled, has mental health or substance misuse problems? If this person would not be able to manage without you, or would have difficulty, you are a carer. By registering that you are a carer with the Practice it could mean that we are able to offer you more support.

Please complete both pages and hand back to reception or post back to us

CARERS REGISTRATION FORM

Please Note
If you have a 'Health and Welfare' Power of Attorney for the person you care for please bring in your original document so that we can record this on our records.

First Name		**Last Name**	
Known as Name		**Date of Birth**	
Address			
Home Number		**Mobile Number**	
Email Address			

Relationship to person cared for i.e. family member or friend:		
Are you a Three Shires patient? If not, you should let your own surgery know that you are a Carer		
I live with the person I care for	**Yes** ☐	**No** ☐
I am their next of kin	**Yes** ☐	**No** ☐
I am their emergency contact	**Yes** ☐	**No** ☐
I am their main carer	**Yes** ☐	**No** ☐

I give consent to being registered as a carer with the surgery:	**Yes** ☐	**No** ☐	
Signed:		**Date:**	

I give permission for my details to be passed to the Carers Support Centre for advice and support	**Yes** ☐	**No** ☐

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CONSENT FROM PATIENT BEING CARED FOR

First Name		**Last Name**	
Known as Name		**Date of Birth**	
Address			
Home Number		**Mobile Number**	
Email Address			

I am a cared for person being cared for by (carers full name):		
I give consent for my health need, medication and treatment to be disclosed to my carer:		
All clinical information	**Yes** ☐	**No** ☐
Test results only	**Yes** ☐	**No** ☐
Appointment information only	**Yes** ☐	**No** ☐
Prescription queries only	**Yes** ☐	**No** ☐
I give consent for the above information about me to be recorded on the clinical record of the person who cares for me. **I give consent for the details of my carer to be held on my medical records.**		

Signed:		**Date:**	