**The Clarkson Surgery**

**DE HAVILLAND ROAD, WISBECH, CAMBS. PE13 3AN**

**DO YOU LOOK AFTER SOMEONE WHO IS FRAIL, DISABLED, ILL OR MENTALLY ILL?**

**AS A SURGERY WE ARE LOOKING TO IDENTIFY CARERS, TO PROVIDE HELP & SUPPORT.**

**UNFORTUNATELY THERE ARE “HIDDEN” OR UNIDENTIFIED CARER’S LOOKING AFTER FAMILY MEMBERS, HELPING A FRIEND OR A NEIGHBOUR WITH EVERY DAY TASKS WHO OFTEN GO UNDETECTED OR DO NOT IDENTIFY THEMSELVES AS A CARER.**

**THERE IS NO DEFINITION TO A CARER, ANYONE CAN BE A CARER.**



**THE ROLE OF A CARER IS AN IMPORTANT & VALUED ROLE.**

**OFTEN 24 HOURS A DAY, IT CAN BE DEMANDING & ISOLATING.**

**AS A CARER, YOU ARE ENTITLED TO HAVE YOUR NEEDS ASSESSED.**

**OUR PCN SOCIAL PRESCRIBERS WILL PROVIDE A FREE CARER’S ASSESSMENT. THEY WILL GIVE YOU THE CHANCE TO TALK ABOUT YOUR NEEDS AND WAYS YOU CAN RECEIVE HELP.**

**THEY WILL ALSO REVIEW THE CARE NEEDS OF THE PERSON YOU CARE FOR.**

**IF YOU FEEL THIS APPLIES TO YOU OR YOU KNOW SOMEONE WHO WOULD BENEFIT FROM THIS HELP, THEN PLEASE ENQUIRE AT RECEPTION TO RECEIVE A “CARERS IDENTIFICATION & REFERRAL FORM”**

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**CARERS IDENTIFICATION & REFERRAL FORM**

**WE WILL PASS YOUR DETAILS ONTO OUR SOCIAL PRESCRIBER TEAM, TO LOOK INTO YOUR NEEDS, AT YOUR REQUEST.**

**YOUR DETAILS:**

|  |  |
| --- | --- |
| Name |  |
| Date of Birth |  |
| Address |  |
| Contact Telephone Number  |  |
| Email Address |  |
| Please refer me to the Social Prescriber team | YES NO  |
| Reason for referral? What help do you require? Please provide information. |  |
| Do you give consent for Clarkson Surgery to record you as a carer on your notes & share information with the PCN Social Prescribing team? | YES NO  |
| Do you consent for the social prescribers team to contact your directly? | YES NO  |
| Carers who provide regular and substantial care are entitled to a Carer’s Health Check? | YES NO  |

**DETAILS OF THE PERSON YOUR CARE FOR:**

|  |  |
| --- | --- |
| Name: |  |
| Date of Birth |  |
| Address (If different from above) |  |
| Contact Telephone number:  |  |
| GP Details (If different from your own) |  |
| Relationship to Carer |  |

**Signature: Date:**