

ALBRIGHTON MEDICAL PRACTICE, SHAW LANE,  
ALBRIGHTON WV7 3DT  
TEL: 01902 372301

## ARE YOU A CARER?

A carer is an unpaid person who looks after a family member, friend or neighbour who because of illness, disability or frailty would be unable to remain at home without their help.

We are interested in identifying carers who may be known to the practice or other statutory agencies. Sometimes these 'hidden' carers are looking after a family member or helping a friend or neighbour with daily tasks and may not see themselves as a carer.

We feel that caring for someone is an important and valuable role in the community, which is often a 24 hour job that can be very demanding and isolating for a carer. We further believe carers should receive appropriate support by way of access to accurate information on a range of topics, such as entitlement to benefits and respite care and not least, a listening ear when things get too much.

If you are a carer this is an opportunity to let the practice know so that we can update our records and pass your name on to the Shropshire Carer Support Service. They will be in touch with you to provide details of their services and if agreeable add your name to their database so that you can receive regular information.

Please complete the following if you have caring responsibilities and would like to be identified as a carer and offered appropriate support, information, immunisations and referrals or pass it to your carer to complete and return it to the surgery.

NOTE: If you are a patient at our surgery but not living in Shropshire, we can give you information on support in your area.

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Title: Mr/Mrs/Miss/Ms

First Name(s): \_\_\_\_\_

Surname: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Date of Birth: \_\_\_\_\_

Telephone: \_\_\_\_\_

Would you like to be referred to Shropshire's carer support service? Yes/No

Your signature: \_\_\_\_\_ Date: \_\_\_\_\_

Details of the Person Being Cared For

Title: Mr/Mrs/Miss/Ms

First Name(s): \_\_\_\_\_

Surname: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Date of Birth: \_\_\_\_\_

Relationship to you: \_\_\_\_\_

Is the person you care for a patient at Albrighton Medical Practice? Yes/No

You will need to obtain signed permission from this person (if they have capacity) to agree for their details to be shared. Otherwise the person who has Power of Attorney can sign on their behalf.

Signature of cared for: \_\_\_\_\_ Date: \_\_\_\_\_

**Please return the completed form to Reception at Albrighton Medical Practice, Shaw Lane, Albrighton, Wolverhampton WV7 3DT**