Lombard Medical Centre

CARERS CONSENT FORM

DETAILS OF PATIENT BEING CARED FOR

Please fill in <u>both</u> sides of this form. This needs to be signed in the presence of a witness.

DETAILS OF PATIENT BEING CARED FOR

Surname: …… First Name: ……..

Date of Birth: …… Tel no: ……

Address: ……..

…… Post Code: ……..

I consent to Mr/Mrs/Ms) ……..

On request being kept informed of my medical condition, treatment and needs

Signed: …… Date: ……

Witness by: Signed ……Date: ……..

Name of Witness (BLOCK CAPITALS) ……..

Address of Witness: ……..

……

PLEASE ENSURE THAT IF ANY OF THE ABOVE DETAILS CHANGE INCLUDING THE TELEPHONE NUMBER YOU INFORM US

Lombard Medical Centre

PTO

CARERS CONSENT FORM

DETAILS OF CARER

Surname:…… First Name: ……

Address:……

……Post Code:……

Title:Mr/Mrs/Ms/Other(Please specify) ……..

Telephone: Home…… Work/Mobile ……

I consent to my details being held in the computerised medical records of the above patient as a carer

Signed: …….. Date: ……..

Witness by: Signed ……Date: ……..

Name of Witness (BLOCK CAPITALS) ……

Address of Witness: ……..

……..

PLEASE ENSURE THAT IF YOU CHANGE ANY OF THE ABOVE DETAILS INCLUDING YOUR TELEPHONE NUMBER YOU INFORM US

Please return to Lombard Medical Centre, 2 Portland Street, Newark, Nottinghamshire NG24 4XG