

GP CARER SUPPORT REFERRAL FORM

Carers Name: _____

Address: _____

Tel: _____ D.O.B: _____

Cared for person's name: _____

Relationship to Carer: (e.g. son, wife, friend etc)

D.O.B: _____

Disability/illness: _____

Name of GP: _____

Name of Practice: _____

I consent for my contact details to be kept on a list by:

(PLEASE TICK)

My GP

The Belfast Health & Social Care Trust

SIGNED: _____

Date: _____

(PLEASE TICK)

Would you like to receive carer information from the Belfast Trust?

YES **NO**

**Would you like to be referred for a carers
assessment? YES** **NO**

Please return form to the Carers Co-ordinator, South & East Belfast and Castlereagh area, Glen Villa, Knockbracken Healthcare Park, Saintfield Rd, Belfast, BT8 8BH