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