**CARERS REGISTRATION FORM**

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

If so, you are a carer and we would like to support you.

Please complete this form and hand it in to reception.

**Your details:**

|  |  |
| --- | --- |
| Name |  |
| Date of Birth |  |
| Address |  |
| Post code |  |
| Telephone number |  |
| Any relevant information |  |
| Email address (for information emails) |  |

**Details of the person you look after:**

|  |  |
| --- | --- |
| Name |  |
| Date of birth |  |
| Address (if different from above) |  |
| Post code |  |
| Telephone number (if different from above) |  |
| GP details (if different from your own) |  |
| Relationship to Carer |  |
| Illness/disability |  |

**Thank you for completing this form. Please return it to the Surgery.**