**Resident Consent Form Guide**

Permission / consent to allow authorised Care Home staff to access information in my GP online record for the purpose of my direct care.

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Care Home name | | |  | | | | | | | | |
| Resident’s name | | |  | | | | | | | | |
| Resident’s date of birth | | | These sections need to be completed with the relevant information. | | | | | | | | |
| Care home address & post code | | |  | | | | | | | | |
| Care Home phone number | | |  | | | | | | | | |
| Current Staff Proxy Users at Care Home to be aligned to above resident. | | |  | | | |  | | | | |
|  | | |  | | | |  | | | | |
|  | | |  | | | | This should list which staff are to be aligned for proxy ordering for this resident. You should receive a staff consent form for all names listed. Ideally more than one staff should be aligned to one resident. | | | | |
| **\*\*Note: One of the next three sections (Resident, Advocate, Care Home Lead/Best Interests Decision) needs to be fully completed\*\***  **Resident**  **One of the next three sections needs to be filled out.** | | | | | | | | | | | **Tick** |
| I am the resident | | | | | | | | | | |  |
| I have read and understood the information leaflet | | | | | | | | | | |  |
| I wish the Care Home to have access to ‘SystmOnline/EMIS Web’ for the following services:  If the resident has capacity, this section should be completed. If they provide written consent all sections need to be completed. If they provide verbal consent, they should tick the verbal box and leave signature space blank. | | | | | | | | | | |  |
| Requesting repeat medications | | | | | | | | | | |  |
| Accessing my summary care record (where defined as necessary and appropriate by your GP) which could include: | | | | | | | | | | |  |
| Medication  Allergies | | Diagnosis  Test Results | | Relevant letters e.g. hospital discharge  Past medical history | | | | | | |  |
| Access to my full medical record  All options which apply should be ticked. | | | | | | | | | | |  |
| Name |  | | | | | Date | | |  | | |
| Signature |  | | | | | | | | | | |
| How was consent given / taken | | | | Written |  | | | Verbal | |  | |

**If the resident does not have capacity to give consent, then consent in the Resident’s best interests can be sought from next of kin, resident’s advocate or Power of Attorney for Health or Care Home Manager (see overleaf).**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Advocate** | | | | | | **Tick** |
| I am the resident’s next of kin or person with legal power of attorney for health | | | | | |  |
| I have read and understood the information leaflet. I agree that the authorised care home staff may access the elements of the GP records via proxy, for direct care, in the best interests of the resident.  All options which apply should be ticked. | | | | | |  |
| I agree that Care Home staff may access to ‘SystmOnline/EMIS Web’ for the following services:  If a resident lacks capacity; residents Power of Attorney (POA), next of kin or advocate should complete the consent form. They should complete this section fully. The name of person providing consent and their signature is needed. | | | | | |  |
| Requesting repeat medications | | | | | |  |
| Accessing my summary care record (this will be at the GPs discretion) which could include: | | | | | |  |
| Medication  Allergies | | Diagnosis  Test Results | Relevant letters e.g. hospital discharge  Past medical history | | |
| Access to my full medical record | | | | | |  |
| Of the resident named overleaf | | | | | | |
| Name |  | | | Relationship to Resident |  | |
| Signature |  | | | Date |  | |
| **Care Home Lead / Best Interests Decision** | | | | | | **Tick** |
| I am the Care Home Manager / Lead of the resident’s Care Home | | | | | |  |
| I have read and understood the information leaflet and agree to allow authorised staff members to access elements of the GP record via proxy, for direct care only, in the best interests of the resident.  All options which apply should be ticked.  The decision is made having satisfied the necessary elements of the Mental Capacity Act 2005. The individual is impaired, and the impairment affects their ability to make the decision. The decision is congruent with any previously expressed wishes and preferences and is made in their best interests.  This section is completed in the best interest of a resident if they are unable to give verbal or written consent or require a best interest decision. This section should be filled out by the home manager or care home lead. | | | | | |  |
| I agree that Care Home staff may access to ‘SystmOnline/EMIS Web’ for the following services:  **For the form to be completed/accepted, they should have:**   1. Residents’ information and care homes details listed. 2. Either resident consent, advocate consent or care home lead/best interest decision section completed fully. 3. Care home signature at the bottom completed. | | | | | |  |
| Requesting repeat medications | | | | | |  |
| Accessing my summary care record (this will be at the GPs discretion) which could include: | | | | | |  |
| Medication  Allergies | | Diagnosis  Test Results | Relevant letters e.g. hospital discharge  Past medical history | | |
| Access to my full medical record | | | | | |  |
| **Signed on behalf of the resident named in the Resident section of this form** | | | | | | |
| Name |  | | | Date |  | |
| Signature |  | | |  |  | |
| **For the Care Home (must be signed)** | | | | | | |
| I confirm I have verified the identity of this resident in accordance with our organisation’s ID verification protocol | | | | | | |
| Name |  | | | Role |  | |
| Signature | This section needs to be completed. If left blank, form should be sent back. If they are doing a Best Interest Decision consent this section still needs to be signed as well. | | | Date |  | |