**Resident Consent Form**

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 | | |  | | | | | | | | |
| Care home address & post code | | |  | | | | | | | | |
| Care Home phone number | | |  | | | | | | | | |
| Current Staff Proxy Users at Care Home to be aligned to above resident | | |  | | | |  | | | | |
|  | | | |  | | | | |
|  | | | |  | | | | |
| **\*\*Note: One of the next three sections (Resident, Advocate, Care Home Lead/Best Interests Decision) needs to be fully completed\*\***  **Resident** | | | | | | | | | | | **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: | | | | | | | | | | |  |
| 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 | | | | | | | | | | |  |
| 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. | | | | | |  |
| I agree that Care Home staff may access to ‘SystmOnline/EMIS Web’ for the following services: | | | | | |  |
| 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.  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. | | | | | |  |
| I agree that Care Home staff may access to ‘SystmOnline/EMIS Web’ for the following services: | | | | | |  |
| 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 |  | | | Date |  | |