# Proxy Access Application Form B

# For cared for patients aged 11 years and over

**Cared for Patient’s Details** (*To give consent for proxy access to their online services)*

|  |  |  |
| --- | --- | --- |
| Name:  |  | Date of Birth: |
| Address: |

**Consent** (to be completed by the person named above unless lacks capacity because of medical condition)

**I give consent for the person named below to have online services access to:**

|  |  |  |
| --- | --- | --- |
| Book/cancel appointments for me | Yes [ ]  | No [ ]  |
| Request my repeat medication | Yes [ ]  | No [ ]  |
| View my core medical record (test results, consultations, allergies, medication etc) | Yes [ ]  | No [ ]  |
| View the immunisations information in my care record | Yes [ ]  | No [ ]  |
| View test results in my care record | Yes [ ]  | No [ ]  |

|  |  |
| --- | --- |
| Signature of patient: |  Date: |

***OR***

**Patient lacks capacity to consent because of medical condition**  [ ]

Please provide copy of legal paperwork (Power of Attorney/Court Appointed Deputy). If paperwork cannot be supplied then GP will need to confirm incapacity before access is given. **\*\*See back sheet\*\***

**Parent/Carer Details** (Requesting proxy access to online services for the patient named above)

*We need these details to be able to trace your existing online user account*

|  |  |  |
| --- | --- | --- |
| Family Name:  |  |  Given Name: |
| Mr [ ]  Mrs [ ]  or ………………. | Male [ ]  Female [ ]  or …………….….. |  Date of Birth: |
| Address: |
| Registered at: Beechwood Medical Practice [ ]  Other Practice [ ]  …………………………………….. |
| Email address:Consent to email registration details [ ]  (*if registered at another practice)* |
| Relationship to patient above: Mother [ ]  Father [ ]  Carer [ ]  Other family member [ ] ……………… |

|  |  |
| --- | --- |
| Signature of parent/carer: |  Date: |

***TURN OVER FOR ID AND PAPERWORK CHECK***

# ------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

# Identity Verification: Practice use only *(staff member to complete when giving registration details to patient)*

|  |  |
| --- | --- |
| **Identity verified by**Staff Member Name:……………………..Signature:………………………………... | Responsibility for patient verifiedParent/Carer ID seen [ ]  Lasting Power of Attorney paperwork seen, and copy taken – please attach to this document [ ]  GP required to confirm patient lacks capacity as documentation not available [ ]  |

***Please hand this form to reception – if your request is not actioned within 1 week then please contact us***

If you are registered with us, access will be added to your existing Online Services account – you will be able to switch to child/cared for person’s account via Linked Users (in drop-down menu under your name). If you are registered elsewhere, we will email you the registration document you need in order to link your account to our practice patient.