Better Health Better Self Referral Form

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| ***Please complete ALL the sections*** and return the completed form to the Better health teamBy email to; betterhealthbetterself@chorley.gov.uk**Referrals will be accepted from GP’s, Nurses, Social prescribers, Link workers & Self Ref**For more information telephone asking for **Tracey Bee 07811 234 336** |

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| **Exclusion Criteria – if the client is suffering from any of the following you will be unable to refer** |
| Women who are pregnant or breastfeeding | [ ]  | Severe mental health  | [ ]  |
| Diagnosed eating disorder | [ ]  | Complex needs identified by GP | [ ]  |
| Underlying medical condition for obesity | [ ]  | Under 16 years of age | [ ]  |
| Medical condition requiring specialised dietary advice | [ ]  | BMI less than 25 or over 45 | [ ]  |

**\*\*\* Please note – If any of the above are highlighted/ticked,**

**you are unable to refer your client to this programme. (From the red box above) \*\*\***

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| **Client has supported the referral to this programme and their GP supports an increase in gentle physical activity for this client, should they wish to take part in the health walks** | Choose an item. |

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| **Client Details** |

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| **Client patient criteria to access the program** | 26– 45 BMI 18 years old and aboveLiving within Chorley Borough |
| **Date of Referral** |  |
| **Name** |  |
| **Address** |  |
| **Postcode**  |  |
| **Date of Birth** |  |
| **Contact Number** |  |
| **E-mail address** |  |
| **NHS Number** |  |
| **Gender** | Choose an item. |
| **Ethnic Group** | Choose an item. |
| **Religion** | Choose an item. |
| **Employment Status** | Choose an item. |
| **Sexual orientation** | Choose an item. |
| **Is the client pregnant** | Choose an item. |
| **Disability, if any (select main and list any additional please)** | Choose an item. | **Any additional;** |
| **Is the client on the Severe Mental Illness register?** | Choose an item. |  |
| **Is the client on the Learning Disabilities register?** | Choose an item. |  |
| **Please provide the clients Weight (kg)****In Kilograms to three decimal places** |  | Weight measured by professional.Choose an item. |
| **Height (m)****In meters to two decimal places** |  | Height measured by professional.Choose an item. |
| **BMI** |  |
| **Client medical conditions, if any (select main and list any additional please)**Choose an item. |

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| **Consent: (All referrals must be signed)** |
| I confirm that this client is suitable for the programme, is over 18, and is living within the Chorley locality. | Choose an item. |
| I confirm that I have discussed the service with the client, they agree and give consent for information to be provided to the Better Health Team and are motivated to lose weight. | Choose an item. |
| I confirm that the client is aware that the programme is an initial 10-week course. However, the Better Health team will provide support for a year, requiring contact during that time with the client. | Choose an item. |
| **Referrer contact details (name, e-mail, telephone number)** |  |
| **Signature of refer** |  |
| **Date** |  |
| **GP Surgery Address** |  |
| **Name of GP**  |  |
| This information will be treated as private and confidential and will be collected by the Better Health Better Self Team for the delivery of the programme. This information will be held by the Better Health Better Self Team and processed in accordance with the Data Protection Act 1998. This information will only be shared with services that the patient has consented to share with. |