REFERRAL FORM

To be completed by the referring Health Professional

All patient data is stored securely in accordance with Data Protection guidelines

Patient Details:						
Title:	Mr/Mrs/Ms/Miss/Other:	**Date of Birth:**				
First Name		**Age: (if under 18)**				
Surname:		**Gender:**	Male	☐	Female	☐
Address:						
Postcode:		**NHS Number:**				
Telephone:		**Mobile:**				
Email:						
Parent/Carer Name:		**GP Surgery:**				

Medical Conditions / Relevant Conditions:						
	Advanced Liver Disease	☐	Anxiety/Depression	☐	Asthma	☐
	Cardiovascular Disease	☐	Chronic Fatigue Syndrome	☐	Dementia	☐
	Dyslipidaemia	☐	Epilepsy	☐	Fibromyalgia	☐
	Hypertension	☐	Learning Disability	☐	Musculoskeletal Disorders (MSD)	☐
	Osteoporosis	☐	Post Bariatric Surgery	☐	Pre Bariatric Surgery	☐
	Recent Falls/Fractures	☐	Severe Mental Illness	☐	Sleep Apnoea	☐
	Type 1 Diabetes	☐	Type 2 Diabetes	☐	Other (please state)	☐

Does the patient want to make lifestyle changes?	Yes	☐	No	☐
Has the patient previously attended weight loss interventions? (e.g. CHIP, Weigh2Go, Commercial Weight Loss)	Yes	☐	No	☐
Has the patient been referred as the result of an NHS Health Check?	Yes	☐	No	☐

Referrer Name:		**Referral Job Title:**	
Referring Organisation:		**Referral Date:**	

Everyone Health Cambridgeshire

Health Trainer Services	Diet/Healthy Eating	☐	Physical Activity	☐	Smoking	☐
	Alcohol Intake	☐	Emotional Wellbeing	☐	Other	☐
Child Weight Management: 7-11yrs old, ≥ 91st centile						☐
Adult Weight Management Tier 2: BMI ≥ 25						☐
Adult Weight Management Tier 3 ▪ BMI ≥ 40 ▪ BMI ≥ 35 with co-morbidities e.g. metabolic syndrome, hypertension, obstructive sleep apnoea (OSA) ▪ An obese individual with complex needs who has not responded to previous Tier 2 interventions ▪ BMI ≥ 35kg/m2 and type 2 diabetes (BMI ≥ 32.5 for Asian population)						☐
Falls Prevention: Age 50+						☐

Measurements

Height:		**Date:**		**HDL:**		**Date:**	
Weight:		**Date:**		**LDL:**		**Date:**	
BMI:		**Date:**		**Total Cholesterol:**		**Date:**	
Blood Pressure:		**Date:**		**Triglycerides:**		**Date:**	
				HbA1c:		**Date:**	

Other Considerations/Co-Pathologies:

Relevant Medication:

Consent:

I confirm that the patient has agreed to share his/her data with Everyone Health	
Referrer's Name:	**Referrer's Signature:**

Please send completed referral form via post or e-mail as below	
Address: **Everyone Health** Everyone Health Fenland District Council Melbourne Avenue March Cambridgeshire	**Email:** Eh.changepointcambs@nhs.net changepointcambs@everyonehealth.co.uk

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