Everyone Health

Hackney Services

REFERRAL FORM

To be completed by the referring Health Professional

All patient data will be kept securely and in accordance with Data Protection and Caldicott guidelines

Patient Details:												
Title:	Mr	☐	Mrs	☐	Ms	☐	Miss	☐	Other	☐		
First Name					**Date of Birth:**				**Age:**			
Surname:					**Gender:**		Male		Female	☐		
Address:												
Postcode:					**NHS Number:**							
Telephone:					**Mobile:**							
Email:												
Parent/Carer Name:					**GP Surgery:**							
Medical Conditions / Relevant Conditions:	Anxiety/Depression	☐	Asthma	☐	Cardiovascular Disease	☐						
	Chronic Fatigue Syndrome	☐	Dyslipidaemia	☐	Epilepsy	☐						
	Fibromyalgia	☐	Hypertension	☐	Learning Disability	☐						
	Musculoskeletal Disorders (MSD)	☐	Osteoporosis	☐	Post Bariatric Surgery	☐						
	Pre Bariatric Surgery	☐	Severe Mental Illness	☐	Sleep Apnoea	☐						
	Type 1 Diabetes	☐	Type 2 Diabetes	☐	Other (please state)	☐						
Please confirm the patient is at the correct stage of behaviour change:							Yes	☐	No	☐		
Referrer Name:					**Referral Job Title:**							
Referring Organisation:					**Referral Date:**							

Service:	
Tier 2 (Child – BMI ≥ 91st centile. Adult – BMI ≥ 25 with high waist circumference, BMI ≥ 30)	☐
Tier 3 (Child – BMI ≥ 98th centile. Adult - BMI ≥ 35 with comorbidities, or ≥ 40 without)	☐

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

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Other Considerations/Co-Pathologies:

Relevant Medication:

Referrer`s Details:	
Referrer`s Address:	
Referrer`s Contact Number:	
Referrer`s Email Address:	

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

Please return the completed referral form to:

Eh.ankhackney@nhs.net