Healthy Lifestyle Service Referral Form

For further assistance, please contact our of our advisors on 01225 831852

Please read the guidance notes carefully before completing this form and then fill in all the relevant sections and submit it to us via one of the methods shown below. Please **complete all sections** having considered all the services you would like us to offer your patient/client taking into account their lifestyle change needs. Sorry we will are unable to accept incomplete forms.

By Post: Healthy Lifestyle Service, The Hub, Ground Floor, Midford House
St Martin's Hospital, Clara Cross Lane, Bath, BA2 5RP

This information is Private and Confidential. It is collected by the Virgin Care Healthy Lifestyle Service for the purpose of delivering lifestyle interventions & will be held in accordance with the Data Protection Act

Patient/Client Details:

Date of Referral		NHS Number of Patient (If known)			
Name			Gender	M / F	
Address (incl. Postcode)			Date of Birth		
			Is patient/client pregnant? Y / N	Y / N	
Home Telephone Number		Consent to leave message? Y/N	Y / N		
Mobile Telephone Number		Consent to leave message? Y/N	Y / N		
		Consent to send SMS? Y/N	Y / N		
Email Address		Consent to send email? Y/N	Y / N		
GP and Surgery Name					

I wish to refer my patient/client for the Healthy Lifestyle service(s) below:
Please put an **x** in the box of all that apply

Stop Smoking Support		Diabetes Education – Those 'At Risk' (HbA1c 42–47)			
Weight Management *(16+)*		Diabetes Education - Diabetes Type 2* (HbA1c => 48)			
Bath City Farm		*Diagnosis Date (Diabetes Type 2 only)			
Green Links		Gentle Exercise *(Wellbeing Walks – 30 Minutes)*			
Passport to Health/Diabetes Please specify area required	Bath/Keynsham/Chew Y/N		Midsomer Norton/Writhlington Y/N		
Food & Health – HENRY programme for Parents/Grandparents with children 0 – 5 yrs.					
Food & Health – Family Cook It programme for Parents/Grandparents with children 5 – 17 yrs.					

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<u>All</u> Sections must be completed (Where no result is available please enter NR)

Height (m)		Weight (kg)		BMI		BP	/
Total Cholesterol		LDL		HDL		HbA1c	

Is your patient /client?	Inactive (<60 a wk.) Y/N		A smoker Y/N		Overweight/Obese Y/N	

Current Medications *(Print and attach patient prescriptions)*		
Passport to Health Only: **Reason for referral** (Put X in all boxes applicable) *(Print and attach patient summary)*	Inactive (less than 60 minutes a week)	
	Depression	
	Stress and Anxiety	
	Weight Management	
	Family history of Coronary Heart Disease	

Please list any other relevant information on medical history/learning disabilities/physical restrictions:	
Is the patient/client motivated to undertake a programme of exercise? Y / N	
Is the patient/client clinically stable and compliant with medications? Y / N	
Does the patient/client have any contraindication to exercise? Y / N	
Has your patient/client consented to this referral being made? Y / N	

Please complete for Food & Health referrals only: DOB and Name(s) of Child(ren):	

Referrer Details

Referrer Name/ Organisation/GP Surgery			
Telephone Number		Occupation	
Email Address			

<u>Sirona Healthy Lifestyle Service Use Only</u>: How did the patient/client find out about HLS Service ……

Date rec: …… Actioned By: …… Date entered on SystmOne: ……Postcode Area: ……

Client Contact: <u>Call 1</u> – Y / N Date …… NC / LM / CM <u>Call 2</u> – Y / N Date …… NC / LM / CM

UTC: Letter sent on: Date: …….. Service outcomes ……

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