**Admin only:**

Client ID No: . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

Date Received: . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

LIFESTYLEs REFERRAL FORM

Tel: Free phone 0300 003 0818

**Please complete each relevant section as fully as possible**

First Name: NHS No:

Surname: D.O.B. Sex: M/F

Address: Home Tel No:

Mobile No:

Works No:

Name of GP:

Practice:

Post Code:

Email Address:

Referred By:

**Please tick**

GP PN HV/Community Nurse Cardiac Rehab Physio Dietician

Self-Referral Another Lifestyle Advisor Stroke Team Other (please specify)

Blood Pressure

Heart Rate

Height

Weight

B.M.I.

Waist Circumference

**Please tick PROGRAMME(s) required:**

**Stop Smoking Programme**

NRT BUPROPION (ZYBAN) VARENICLINE (CHAMPIX) NONE

**Why Weight Healthy Weight Programme** for clients with a BMI 30+ or BMI 28+ with co-morbidities

 **Possible candidate for Bariatric Surgery** for clients with a BMI over 40+ or 35+ with major co-

morbidities

**Reach for Health Exercise Programme**

**Stay on Your Feet Exercise and Education Programme for later life (65 years plus)**

**Books on Prescription**

**Suitable for Group Consultation**

Reason for referral: . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

**Relevant Medical History:**

**Current Medication:**

**Please return to:** Healthy Lifestyles, Orford Jubilee Park,

First Floor, Jubilee Drive, Orford, Warrington, WA2 8HE

**Fax: 01925 625325**

**Email:** [**livewire.lifestyles@nhs.net**](mailto:livewire.lifestyles@nhs.net) **or** [**lifestyles@livewirewarrington.org**](mailto:lifestyles@livewirewarrington.org)

**Client consent to refer to Wellbeing Mentors:**

Yes No 

Client signature: . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

Date: . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

**Office Use Only**

**Client in receipt of:**

Personal Independent Allowance (PIPS)

Disability Living Allowance (DLA)

Carers Allowance

Students 16 years plus in full time education

60 years plus

Universal Credit

Income Support

Job Seekers Allowance

Employment and Support Allowance

Housing Benefit

Working Tax Credit

Council Tax Benefit

6 & 12 month follow up

Advertisement

Medical Professional

Word of Mouth

Social Media

Friend/Relative

Website

Neighbourhood & Wellbeing Team

**How did client hear about the service?**

Other . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

**Data Protection Information Declaration** All the information collected on the Client Record Form will be dealt with confidentially by the Lifestyles Team under the (HSC 2000/09) Data Protection Act 1998. Information will only be used by the Lifestyles Team to audit outcomes, plan further services, and offer client follow up if required. Data may be shared anonymously with supporting partners.

**Data Protection Client Declaration**

I agree to the above YES NO 

I acknowledge the information given above is correct to the best of my knowledge at the time of completion. I undertake to inform you immediately if any of the above changes.

Signed: . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .