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Cambridgeshire Lifestyle Service Referral Form

To be completed by the referring Health Professional
All patient data is stored securely in accordance with Data Protection guidelines.
If you have a query concerning a referral please contact: 0333 005 0093.

Patient Details

Title:	○ Mr ○ Mrs ○ Miss ○ Ms ○ Other	**Date of Birth:**	DD / MM / YY
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:		**Referrer Job Title:**	
Referring Organisation:		**Referral Date:**	DD / MM / YY

Service

Health Trainer Services	○ Diet/Healthy Eating ○ Alcohol Intake	○ Physical Activity ○ Emotional Wellbeing	○ Smoking ○ Other please state below

○ **Child Weight Management:** 7-11yrs old, BMI ≥ 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 65+

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Measurements

Height (cm):		Date: DD / MM / YY
Weight (kg):		Date: DD / MM / YY
BMI:		Date: DD / MM / YY
Blood Pressure:		Date: DD / MM / YY

HDL:		Date: DD / MM / YY
LDL:		Date: DD / MM / YY
Total Cholesterol:		Date: DD / MM / YY
Triglycerides:		Date: DD / MM / YY
HbA1c:		Date: DD / MM / YY

Other Considerations/Co-Pathologies

Relevant Medication

Please provide medication information below, or attach a copy of their prescription with medication information.

Consent

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

Please send completed referral form via post, secure eFax or e-mail as below:

Address: Everyone Health
10 Bennell Court,
West Street,
Comberton,
CB23 7EN

Fax: 01223 281409
Email: changepointcambs@everyonehealth.co.uk
EH.ChangePointCambs@nhs.net