

 **Patient details**

 **Name:** …………………………………………………………………………………………………………………………………………

 **Date of Birth:** ……………………………………………………………………………………………………………

 **NHS Number**: ……………………………………………………………………………………………………………

 **Gender:** ……………………………………………………………………………………………………………

**Preferred contact number**……………………………………………………………………………………………………………

 **Address:**

…………………………………………………………………………………………………………………………………………

…………………………………………………………………………………………………………………………………

**Email:** …………………………………………………………………………………………………………………………………………

 **Name of Referrer and GP Practice/Organisation:**

…………………………………………………………………………………………………………………………………………

* **This patient is aware of and consents to this referral**
* Contact consent
* **Adult Weight management**
* **Physical Activity On Referral**
* **Stop Smoking Service**

**Interpreter Required Please specify** …………………………………………………………………………………………………………………………………………

**Reason for referral:**

* **Long term health conditions**
* Cancer (Please specify) …………………………………………………………………………………………………………………………………………
* Cardio (Please specify)

…………………………………………………………………………………………………………………………………………

* Pulmonary (Please Specify)

…………………………………………………………………………………………………………………………………………

* MSK(Please Specify)

…………………………………………………………………………………………………………………………………………

* Obesity
* Mental wellbeing (low level anxiety, low level depression or stress)
* Current smoker
* Alcohol Drinker
* Pre-diabetes
* Diabetes type 1
* Diabetes type 2
* CVD Risk
* Pregnancy
* Pre-Natal
* Hypertension

Current BMI (**Mandatory**)

…………………………………………………………………………………………………………………………………………

BP:

…………………………………………………………………………………………………………………………………………

**List of Current Medication:**

…………………………………………………………………………………………………………………………………………

……………………………………………………………………………………………………………………………………………

**Other important information:** ………………………………………………………………………………………………………………………………………

Please email this form to clinical.contactcentre@nhs.net

For AWM waiting list please email eh.fitterfutures@nhs.net