Eat 4 Health GP & Health Professional Referral Form

Please note this form must only be completed by a Health Professional once completed please send to: Eat 4 Health Team, Solutions 4 Health, Thames Court, 2 Richfield Ave, Reading, RG1 8EQ - Tel: 01183 341 864 or Fax: 01189007497 Secure Email: eat4.health@nhs.net Web: www.eat-4-health.co.uk

Auto populating E4H referral forms are available on DXS and in Emis, Vision, Systm One (tpp) formats, please contact the team for more information

Referral date

Title Mr | Mrs | Miss | Ms

Full Name

Client's contact details

Gender ☐ Male ☐ Female

Address .....

..... Postal code:.....

Tel (home):..... Mobile: ..... Email:.....

Date of Birth

NHS Number

Measurements: Height: ..... Weight: ..... BMI: ..... Waist circumference: ..... Blood Pressure: .....

Health and Medical Information

If you have ticked any boxes please provide further information on their clinical diagnosis and current problems

- Arrythmia ☐
- Angina ☐
- Joint Pain ☐
- Impaired alertness ☐
- Dizziness/Falls ☐
- Hypoglycaemia ☐
- Abnormal muscle tone ☐
- Impaired cognition ☐
- Hypotension ☐
- Asthma ☐
- Osteoperosis ☐
- Raised cholesterol/triglycerides
- Established cardiovascular disease ☐
- Sleep apnoea ☐
- Osteoarthritis ☐
- Hypertension ☐
- Previous Stroke/TIA ☐
- Severe Lower Limb Joint Disease ☐
- Polycystic Ovarian Syndrome (PCOS) ☐
- Type 1 Diabetes ☐
- Type 2 Diabetes ☐
- Pre Diabetes ☐
- Previous bariatric surgery ☐

(Please specify).....

Learning Difficulty or Disability: ☐

(Please specify).....

Please note if E4H is not safe/suitable for your patient the referral will be declined.

Other:.....

Medication

1..... 3..... 5.....

2..... 4..... 6.....

Possible effects of current medication and/or diagnosis on patient's safe/comfortable conduct of exercise:.....

.....

Suitability to exercise - *Each E4H session contains 45 minutes of light physical activity, which can be modified by the qualified instructor to suit patients fitness ability and mobility level. Do you feel at the current time this patient is suitable to participate in exercise? Please note if this field is left blank the form will be be returned.*

Yes ☐ No ☐

GP contact details

Name.....

Address .....

.....

Postal code:..... Tel:.....

Referrer Details

Name.....

Job title .....

Signature .....

Work address .....

..... Tel:.....

Referral reason: ☐ Lose weight ☐ Improve fitness

☐ Other: .....

Please confirm that the service user is motivated and has agreed to this referral ☐

PATIENT INFORMED CONSENT This scheme has been fully explained to me. I wish to decrease my current weight by participating in the scheme. I give my consent for any relevant clinical information about my health and participation on this scheme to be used for evaluation and monitoring purposes. I consent to my information being stored on a database for audit purposes (in accordance with the Data Protection Act 1977)

Name (PRINT).....

Signature .....

Date:.....

OFFICE USE ONLY

Date referral received:..... Date of first appt offered .....

Date of first contact attempted:..... First date declined

Date of first contact made (if different) ..... Date of first appt .....

(To be filled only by GP/Health professionals only) Suitability to exercise field must be completed.

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