# LiveWellDorset-big.tif



Referral Form

# LiveWell Dorset is a health improvement service offering behaviour change support to individuals. The service supports people to move more, maintain a healthy weight, drink less and stop smoking.

Note: All patient data will be kept securely and in accordance with the Data Protection Act 1998. Information can only be passed to another healthcare professional if this contributes to the provision of effective care.

Any personal information provided on this form will be held by LiveWell Dorset and Public Health.

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1. Referrer Details: | | | | | | | | | | | | | | |
| Referrer Title (e.g. GP, Practice Nurse, dietician etc) | | | |  | | | | Location/Surgery/ Pharmacy | | | |  | | |
| Name | | | |  | | | | Contact Number or Email | | | |  | | |
| 2. Client Details: | | | | | | | | | | | | | | |
| Surname | | |  | | | First Name | | |  | | | | Mr/Miss/Ms/Mrs | |
| Address | | | Postcode: | | | | | | | | | | | |
| Date of Birth | | |  | | | | Daytime Number | | | |  | | | |
| Email |  | | | | | | Evening / Mobile | | | |  | | | |
| Weight (kg) | |  | | | Height (m) | |  | | | BMI (kg/m2) | | | |  |
| Tick here if the patient is being referred as a result of a NHS Health Check | | | | | | | | | | | | | |  |

To enable us to devise the most appropriate service to meet your needs the following information will be required.

1. **Do you have a disability as described in the definition under The Equality Act 2010 (✓) one only please**

**The Act defines** a disabled person as a person with ‘a physical or mental impairment which has a substantial and long-term adverse effect on his or her ability to carry out normal day-to-day activities’.

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes | Do you have special requirements you wish us to be aware of? If yes please state: | |
|  | No |  | I do no wish to disclose |

1. **Compulsory to be completed by the referrer if:**

Your client is a current (please **✓** as appropriate)

* Mental health service user
* Learning disability client

If yes, then it may be a requirement for a carer/support worker to attend sessions until it is mutually agreed that support is no longer required. This is essential to enable your referred client to be able to gain full benefit of the service provided. A carer/support worker telephone contact number will be required.

Please tick if you **do not** feel a carer/support worker needs to attend with the patient

**Patient’s name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **ETHNIC Origin (✓) one only please**

If the client declines to answer the above questions please **✓**

|  |  |  |  |
| --- | --- | --- | --- |
| White- British |  | Black or Black British – Caribbean |  |
| White – Irish |  | Black or Black British - African |  |
| White – Any other White background |  | Black or Black British - Any other Black background |  |
| Mixed - White & Black Caribbean |  | Chinese |  |
| Mixed - White & Black African |  | Any Other Ethnic Group |  |
| Mixed - White & Asian |  | Asian or Asian British - Bangladeshi |  |
| Mixed - Any other mixed background |  | Asian or Asian British - Any other Asian background |  |
| Asian or Asian British - Indian |  |  |  |
| Asian or Asian British - Pakistani |  |  |  |

1. **Please select all pathways that is of interest to the client:-**

**Smoking Cessation Alcohol reduction Physical Activity Weight Management**

\* Attendance at a Slimming Club provider before the referral process is complete may result in the patient being in-eligible to access the weight management programme

|  |  |
| --- | --- |
| Referrer signature (indicating the service outline has been explained to the client, and the client wants and is ready to take part)  Signature \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_  Date \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ | Client Signature (indicating consent to contact details being passed on to LiveWell Dorset, referral into the service and pass on of outcome data to GP)  Signature\_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_  Date \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ |
| Please send the completed form to  LiveWell Dorset  Lynch Lane Offices  Egdon Hall  Lynch Lane  Weymouth  Dorset  DT4 9DW | | Main Number: 01305 233105; 0800 8401628  Provider Line: 01305 233106  Fax: 0800 0901582  Email: referrals@livewelldorset.co.uk |

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