Please read the guidance notes carefully before completing this form and then fill in all the relevant sections and submit it to us via one of the methods shown below. Please **complete all sections** having considered all the services you would like us to offer your patient/client taking into account their lifestyle change needs. Sorry we will are unable to accept incomplete forms.

|  |  |  |
| --- | --- | --- |
| **By Post:** | | Healthy Lifestyle Service, 2nd Floor, Kempthorne House  St Martin’s Hospital, Clara Cross Lane, Bath, BA2 5RP |
| **Email:** | [BATHNES.thehub@virgincare.co.uk](mailto:BATHNES.thehub@virgincare.co.uk) **Via** **SystmOne:** Electronic referral direct to Virgin Care | |
| **This information is Private and Confidential. It is collected by Virgin Care for the purpose of delivering lifestyle interventions & will be held in accordance with the Data Protection Act** | | |

**Patient/Client Details:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Date of Referral** |  | NHS Number of Patient (If known) |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Name |  | |  | | Gender | M / F | |
| Address  (incl. Postcode) |  | | | | Date of Birth |  | |
| Is patient/client pregnant? | | Y / N |
| Home Telephone Number | |  | | Consent to leave message? | | | Y / N |
| Mobile Telephone Number | |  | | Consent to leave message? | | | Y / N |
| Consent to send SMS? | | | Y / N |
| Email Address | |  | | Consent to send email? | | | Y / N |
| GP and Surgery Name | |  | | | | | |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Stop Smoking Support | |  | Diabetes Education – Those ‘At Risk’ (HbA1c 42–47) | | | | |  |
| Weight Management *(16+)* | |  | Diabetes Education - Diabetes Type 2\* (HbA1c => 48) | | | | |  |
| Bath City Farm | |  | \*Diagnosis Date (Diabetes Type 2 only) | | |  | | |
| Green Links | |  | Gentle Exercise *(Wellbeing Walks – 30 Minutes)* | | | | |  |
| *Passport to Health/Diabetes*  Please specify area required | Bath/Keynsham/Chew | | | Y / N | Midsomer Norton/Writhlington | | Y / N | |
| SHINE Weight Management for children 10-17 Years Old | | | | | | | |  |
| Food & Health – HENRY programme for Parents/Grandparents with children 0 – 5 yrs. | | | | | | | |  |
| Food & Health – Family Cook It programme for Parents/Grandparents with children 5 – 17 yrs. | | | | | | | |  |

**I wish to refer my patient/client for the Healthy Lifestyle Service(s) below:** Please put an **x** in the box of all that apply

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Height (m) |  | Weight (kg) | |  | | | BMI | | |  | | BP | | / | | |
| Total Cholesterol |  | LDL | |  | | | HDL | | |  | | HbA1c | | |  | |
| **Is your patient /client?** | | | Inactive (<60 a wk.) | | | Y / N | | A smoker | Y / N | | Overweight/Obese | | | | | Y / N |
| **Current Medications** *(Print and attach patient prescriptions)* | | | | |  | | | | | | | | | | | |
| ***Passport to Health Only:***  **Reason for referral**  (Put X in all boxes applicable)  *(Print and attach patient summary)* | | | | | Inactive (less than 60 minutes a week) | | | | | | | |  | | | |
| Depression | | | | | | | |  | | | |
| Stress and Anxiety | | | | | | | |  | | | |
| Weight Management | | | | | | | |  | | | |
| Family history of Coronary Heart Disease | | | | | | | |  | | | |
| Please list any other relevant information on medical history/learning disabilities/physical restrictions: | | | | | | | | | | | | | | | | |
| Is the patient/client motivated to undertake a programme of exercise? | | | | | | | | | | | | | Y / N | | | |
| Is the patient/client clinically stable and compliant with medications? | | | | | | | | | | | | | Y / N | | | |
| Does the patient/client have any contraindication to exercise? | | | | | | | | | | | | | Y / N | | | |
| Has your patient/client consented to this referral being made? | | | | | | | | | | | | | Y / N | | | |

|  |  |
| --- | --- |
| **Please complete for Food & Health referrals only:**  DOB and Name(s) of Child(ren): |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Referrer Name/ Organisation/GP Surgery |  | | |
| Telephone Number |  | Occupation |  |
| Email Address |  | | |

**Referrer Details**

**Virgin Care Healthy Lifestyle Service Use Only**: How did the patient/client find out about HLS Service …………………

Date rec: …………… Actioned By: ………… Date entered on SystmOne: ………….Postcode Area: ……

Client Contact: Call 1 – Y / N Date ……… NC / LM / CM Call 2 – Y / N Date ……… NC / LM / CM

UTC: Letter sent on: Date: ……….. Service outcomes …………………………………………………………