REFERRAL FORM

To be completed by GPs, social prescribers or other authorised professional

Date of referral:	**Date referral received: (Office use only)**

Activity Referral
The patient has a diagnosis of SMI. Yes ☐ / No ☐ Has the patient consented to the referral? Yes ☐ / No ☐ The patient has asked to be referred into the Healthy You physical intervention programme as follows (please tick): Feeling Good – Healthy Eating and Weight Management ☐ Small Steps Exercise Programme ☐ Smoking Reduction Support ☐ The patient would like a carer or support worker to attend with them Yes ☐ No ☐ **I recommend the patient for participation in group activities:** Male only ☐ Female only ☐ Mixed gender ☐

Personal Details of Patient (required)	
Forenames:	Surname:
Male/ Female (please circle)	Postcode (first 4 digits): _ _ _ _
Disability: Yes ☐ No ☐ (details of any accessibility requirements)	
Personal Details (optional)	
Tel/mobile no(s):	Email:

Other Contact Details e.g. Next of kin /carer interpreter (if patient wishes to share)	**GP Details:**
Name: Address: Tel No: Relationship:	Name: Surgery address: Postcode: Tel No:

Contact aware of referral? Yes ☐ No ☐	GP aware of referral? Yes ☐ No ☐

Referrer Source/Details:

Name: Role:

Organisation: Tel no:

Email:

Risk Assessment

Are you aware of any concerns or issues in terms of safeguarding? Yes ☐ / No ☐
If yes, please give details if appropriate to share?

Is there anything that the session trainers and support workers need to be aware of? (E.g. medication, physical / sensory / learning difficulties). If so, please seek patient consent if you need to share details.

As far as I am aware the client does not pose any risk to either themselves or others by participating in the group sessions *(please note the trainers and support workers have only basic SMI training)*. ☐

Sharing of Information

I have obtained patient consent for sharing the above information and making this referral.

Yes ☐ / No ☐

Information shared will only be used for the purpose it was intended and will be processed securely according to GDPR legislation.

Signatures

To be signed by the person making the referral: *(GP, Social prescriber or other authorised professional).*

Name: **Organisation:**

Signature:	**Date:**
Service Start Date: (Office Use Only)	

Please upload this completed form to www.cnet.org.uk/Projects/HealthyYou