


## Live Life Better Derbyshire Referral Form


**Please complete ALL sections**


### Section 1 - Client details


Title		Full Name			
Date of Birth		Gender	M <input type="checkbox"/> F <input type="checkbox"/>	NHS No.	
Address				Postcode	
Email address				Home Phone/ Mobile phone	
Preferred contact method	Phone <input type="checkbox"/>	Text <input type="checkbox"/>	Email <input type="checkbox"/>	Post <input type="checkbox"/>	Best time to contact client
					AM <input type="checkbox"/> PM <input type="checkbox"/> EVE <input type="checkbox"/>
GP Name			GP Surgery		
Does this person require any reasonable adjustments?	Yes <input type="checkbox"/> No <input type="checkbox"/>		If yes, please give details		

### Section 2 - Please tick service(s) required

<input type="checkbox"/>		<b>Weight loss programme - This person has a BMI of 25 + and motivated to lose weight</b>					
	Weight	Height	BMI (if known)	Smoker	Alcohol Units/Wk.	Is this person considering bariatric surgery? (must be a non-smoker and meet local commissioning criteria)	Does this person have a BMI >45 and require intensive/specialist support?
				Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/>	Yes <input type="checkbox"/>
<b>Additional Information:</b>							

<input type="checkbox"/>		<b>Stop Smoking - This person smokes tobacco and is motivated to quit</b>
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<input type="checkbox"/>		<b>Wellbeing Worker Support- This person is motivated and requires additional support to improve their wellbeing</b>
Please tell us briefly how we can help (please attach separate notes if required)		

<input type="checkbox"/>		<b>Exercise on Referral - This person has a health condition that can be improved by increasing their physical activity levels</b>
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### Section 3 – Health Conditions

Heart Disease	Diabetes	Joint/Mobility	Respiratory	Hypertension	Anxiety/Depression	Other
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other, please give details						
Please give details of medication or attach prescription						

### Section 4 Other agencies involved in care & any risk issues

Are there any other services involved in this person's care?		Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes please provide contact details for each service		
Please highlight any risk/safety issues we need to be aware of including recent history of verbal &/or physical aggression towards others or inappropriate, anti-social behaviour/substance misuse		

### Section 5 – Consent and referrer's details:

I confirm this person is suitable for the programme, is over 16, (12 for stop smoking) lives in Derbyshire County or is registered with a Derbyshire GP	Yes <input type="checkbox"/>	I confirm the reason for the referral has been explained and the person has agreed consent to be contacted by Live Life Better Derbyshire	Yes <input type="checkbox"/>
Name		Position	
Place of Work		Telephone number	
Signature		Date	

This information will be treated as private and confidential and will be collected by Live Life Better Derbyshire for the delivery of lifestyle interventions. This Information will be held by Live Life Better Derbyshire and processed in accordance with the Data Protection Act 1998. This information will only be shared with services that the patient has consented to share with.

Please email the completed form to [lbd@nhs.net](mailto:lbd@nhs.net) or by post to:

**LLBD Health Promotion Department, Walton Hospital, Chesterfield S40 3HW**

**For more information telephone 01246 515 550**  
or visit our website [www.livelifebetterderbyshire.org.uk](http://www.livelifebetterderbyshire.org.uk)