We need to take some details about you so we can offer you the right services, and so we can monitor and evaluate what we do and help us to improve. The personal information you provide will be stored in line with the Data Protection Act and will not be shared outside of the service *unless* Living Well staff members feel that you could be a danger to yourself/others or that you may be in danger of harm from others – in which case they may contact the local authority or the emergency services. Please tick here if you **DO NOT** agree with the above statement [ ]

**Patient Details:** Mr [ ] Miss [ ] Ms [ ] Mrs [ ] Other [ ] Gender: Male [ ] Female [ ]

First Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Surname\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_/\_\_\_/\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Postcode: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Tel No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Permission given to leave voicemail and/or text client? Yes [ ] No [ ] Best time to make contact? AM / PM

Clients GP Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Practice Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Height \_\_\_\_\_\_\_\_\_\_\_\_cm Weight \_\_\_\_\_\_\_\_\_\_\_\_kg Language support? Yes [ ] No [ ]

BMI \_\_\_\_\_\_\_\_\_\_\_\_\_\_ (If known) Please state: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Equal Opportunities:**

Ethnicity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physical Disability? Yes [ ] No [ ] Pregnant? Yes [ ] No [ ]

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Military Veteran? Yes [ ] No [ ] Carer? Yes [ ] No [ ]

Sexual Orientation: Lesbian / Gay / Bisexual / Heterosexual

**This is not a clinical service and we cannot provide advice on medical conditions.** We may need to share information with your GP. Please tick here if you **DO NOT** agree to your details being shared with your Doctor [ ]

**What would you like support with?**

Short Courses 

Stop Smoking  Building Confidence  Gym/Exercise  Slimming World 

Being more Active  Health Walks  Healthy Eating Weight Watchers 

Stress  Low Mood Reducing Alcohol intake  Weight Management 

**Are there any condition(s) that we need to be aware of or take into account when working with you?** Yes [ ] No [ ] please state below:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**How did you hear about us? GP/Agency Referral:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Word of mouth** |  |  | **GP/ Agency Name** |  |
| **Website** |  |  | **Name of referrer** |  |
| **GP** |  |  | **Telephone** |  |
| **Friends/family** |  |  | **Fax** |  |
| **Poster/leaflet** |  |  | *I know of no reason why this person may not* *undertake a structured exercise referral course* |
| **Other** |  |  | *Please tick to confirm you have included the  ‘Encounter Report’ for medication & conditions* |
|  |  | *If the BMI is greater than 35 please refer onto the Healthy Weight Team on Tel: 01706 901763* |

**Please return to:** **Tel: 01706** **751190 FAX: 01706 396060 EMAIL: livingwellhmr@biglifecentres.com**