**Wellbeing Single Point Referral Form
Secure Email referral to: chcp.sthelens@nhs.net**

**Part One: Patient Information**

**Patient Information Details**

|  |  |
| --- | --- |
| **NHS Number** | **Name** |
| 00000 000 000 | Title | Forename | Surname |
| **Date of Birth** | **Gender** | **Ethnicity** |
| Date of Birth | Gender | Ethnicity |
| **GP Name** | **GP Practice Address** | **GP Practice Code** |
| GP Name | GP Practice Address | GP Practice Code |

 **Patient Contact Details**

|  |  |  |
| --- | --- | --- |
| **Phone** | **Mobile** | **Email** |
| 00000 000 000 | 00000 000 000 | Email |
| **Address** | **Postcode** |
| Address | Postcode |
| **(If patient under 18yrs) Parent / Carer Full Name** | **Contact** |
| Parent / Carer Full Name | 00000 000 000 |

 **Referrer Details**

|  |  |
| --- | --- |
| **Referrer Name** | **Referrer Job Title**  |
| **Referrer Name** | **Referrer Job Title**  |
| **Referrer Address (if different to above)** |
| Referrer Address |

 **Patient Medical Information**

|  |  |  |  |
| --- | --- | --- | --- |
| **Height** | **Weight** | **BMI** | **Date of last measurements** |
| Height in cm | Weight in kg | BMI | Date of last measurements |
| **Blood Pressure** | **Resting Heart Rate** |
| 000 / 000 | Date of reading | Resting Heart Rate | Date of reading |
| **HbA1c or Fasting Glucose** | **TFTs** |
| HbA1c mmol/L | Date of reading | TFTs | Date of reading |
| **Full lipid profile** | **Cholesterol** | **HDL** | **LDL** | **Triglycerides** |
| Date of test | Cholesterol | HDL | LDL | Triglycerides  |

**Additional Information**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Communication** | **Contact**  | **Format** | **Professional** |
| **Communication Needs** | Please select | Please select | Please select | Please select |
|  |
| Please include any relevant additional patient / medical information, including any special requirements, that we need to be aware of to enable the patient to engage with our services  |

**Where all information is not known, please send through to GP to make a referral. Attach separately any concerns or further information to be included about the patient’s situation, medical details, and current medication to help facilitate their wellbeing plan.**

**Part Two: Referral Information**

**St Helens Wellbeing provide a range of services and support for individuals and families. Please discuss with the patient and indicate below which support they are to be referred:**

|  |  |
| --- | --- |
|[ ]  **Get Active / Exercise** | General exercise advice and activities for all the family through to specialist exercise advice for a range of health conditions |
|[ ]  **Alcohol Reduction** | Support for patients with an **AUDIT score of 15 and under** (Lower to Increasing Risk) |
|[ ]  **Infant Feeding** | [ ]  Birth+ - Breastfeeding / Infant Feeding Support[ ]  4 - 12 months - Introducing Solid Foods Education[ ]  1-4 years - Eating Well Programme |
|[ ]  **Diabetes Prevention**  | Aged 18 and over with **HbA1c 42-47 mmol/L** or FPG 5.5-6.9 mmol/L **within last 12 months** or history of **Gestational Diabetes Mellitus**. Service delivered by Reed Wellbeing |
|[ ]  **Healthy Eating** | Guidance around basic food, nutrition, portion sizes following the Eatwell Guide |
|[ ]  **Social Prescribing** | Holistic approach to help clients with navigating support for finance issues, housing, employment, loneliness / isolation as well as physical health and wellbeing improvements |
|[ ]  **Stop Smoking** | Specialist stop smoking support for smokers aged 12 and over |
|[ ]  **Weight loss / Obesity Management** | [ ]  **General Weight Management** Support for adults looking to achieve a healthy weight and improved lifestyle through healthy eating and exercise advice. [ ]  **Tier 3 Specialist Weight Management****Adults**: BMI >35 with co-morbidities; BMI >40 or BMI >30 with Type 2 Diabetes or pregnant * Patient meets the full acceptance criteria for referral
* Patient wants to be considered for bariatric surgery; check if referrer is in agreeance [ ]
* Patient is aware the service *does not* prescribe medication, including for weight loss

**Children**: >98th Centile (bloods not required)**Blood test results and physiological measurements (recorded within Patient Medical Information) must be within the last 3 months** |

By referring this patient to the Wellbeing Service, as part of their intervention they may be offered a programme of exercise. **Please indicate if** **patient is clinically unsuitable for an exercise intervention:** [ ]

**Confirmation**

**In signing below, as the patient’s referrer, I confirm that:**

* **The Wellbeing Services offer has been discussed with the patient and they consent to be referred**
* **The patient agrees to be contacted via phone, SMS text message or email**

|  |  |
| --- | --- |
| **(Digital) Signature of referring clinician** | **Date of referral** |
| Referrer Signature | Date |