Shape Up 4 Life GP & Health Professional Referral Form

Please note this form must only be completed by a Health Professional. Once completed please send to: Secure Email: shapeup4life.wiltshire@nhs.net or Fax: 44 1249431055. Tel: 0800 246 5877 or 01183 341 864 Web: www.shapeup4-life.co.uk Shape Up 4 Life Team, Solutions 4 Health, Thames Court, 2 Richfield Ave, Reading, RG1 8EQ **Auto populating SU4L referral forms are available on Systm One, please contact the team for more information**

Referral date

Title Mr | Mrs | Miss | Ms

Full Name

Client's contact details

Gender ☐ Male ☐ Female

Date of Birth

Address .....

..... Postal code:.....

NHS Number

Tel (home):..... Mobile: ..... Email: .....

Measurements: Height: ..... Weight: ..... BMI: ..... Waist circumference: ..... Blood Pressure: .....

Health and Medical Information

If you have ticked any boxes please provide further information on their clinical diagnosis and current problems

- Arrythmia ☐
- Angina ☐
- Joint Pain ☐
- Impaired alertness ☐
- Dizziness/Falls ☐
- Hypoglycaemia ☐
- Abnormal muscle tone ☐
- Impaired cognition ☐
- Hypotension ☐
- Asthma ☐
- Osteoperosis ☐
- Raised cholesterol/triglycerides
- Established cardiovascular disease ☐
- Sleep apnoea ☐
- Osteoarthritis ☐
- Hypertension ☐
- Previous Stroke/TIA ☐
- Severe Lower Limb Joint Disease ☐
- Polycystic Ovarian Syndrome (PCOS) ☐
- Type 1 Diabetes ☐
- Type 2 Diabetes ☐
- Pre Diabetes
- Previous bariatric surgery ☐

(Please specify).....

Learning Difficulty or Disability: ☐

(Please specify).....

Please note if SU4L is not safe/suitable for your patient the referral will be declined.

Other:.....

Medication

1..... 3..... 5 .....

2..... 4..... 6 .....

Possible effects of current medication and/or diagnosis on patient's safe/comfortable conduct of exercise: .....

.....

GP contact details

Name.....

Surgery .....

.....

Postal code:..... Tel:.....

Referrer Details

Name .....

Job title .....

Signature .....

Work address .....

..... Tel:.....

Referral reason: ☐ Lose weight ☐ Improve fitness ☐ Other: .....

Please confirm that the service user is motivated and has agreed to this referral ☐

Patient informed Consent Solutions4health would encourage you to provide your consent in order that we can process data and information about you. We will share this data where necessary with other health professionals such as your GP or specialist services. The information we collect and process will be used to help us meet the contractual obligations as set down by the local health service commissioners in accordance with the service we are providing. You can request to view, amend or delete your data at any time by contacting us at (www.solutions4health.co.uk/contact).

Consent Provided ☐

Signature .....

Date: .....

Office Use Only

Date referral received:..... Date of first appt offered.....

CONFIDENTIAL (To be filled only be GP/Health professionals only