Eat4Health
Free support for better health

Solutions4Health

Reading Borough Council
Working better with you

West Berkshire COUNCIL

WOKINGHAM BOROUGH COUNCIL

Eat 4 Health - Weight Management Service Referral Form

Please send completed form to: Eat 4 Health Team, Solutions 4 Health, Thames Court, 2 Richfield Ave, Reading, RG1 8EQ - Tel: 0118 449 2036 or 0800 772 0630
Web: www.eat-4-health.co.uk Email: info@eat-4-health.co.uk

Referral date

Title Mr | Mrs | Miss | Ms Full Name

Client's contact details

Gender ☐ Male ☐ Female

Date of Birth

NHS Number

Address ....

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

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

Baselines Measures

Heart Rate (Resting) .... Heart Rate (Regular) .... Blood Pressure ....

Health and Medical Information

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

Arrythmia	☐	Abnormal muscle tone	☐	Sleep apnoea	☐	Previous bariatric surgery	☐
Skin irritation	☐	Impaired cognition	☐	Osteoarthritis	☐	Food Allergy	☐
Angina	☐	Hypotension	☐	Hypertension	☐	Diagnosed mental health condition:	☐
Joint Pain	☐	Asthma	☐	Previous Stroke/TIA	☐	*(Please specify)*..	
Impaired alertness	☐	Osteoperosis	☐	Severe Lower Limb Joint Disease	☐	Other:	☐
Dizziness/Falls	☐	Urinary frequency	☐	Polycystic Ovarian Syndrome (PCOS)	☐	*(Please specify)*..	
Hypoglycaemia	☐	Raised cholesterol/triglycerides	☐	Type 1 Diabetes	☐	Pregnant	☐
Infection	☐	Established cardiovascular disease	☐	Type 2 Diabetes	☐	Disability	☐

Further information:..

Medication

1.. 3.. 5 ....

2.. 4.. 6 ....

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

....

Prohibited Activity *(please indicate any activities that you DO NOT wish the client to take part in)*

Cardiovascular gym ☐ Aquafit ☐ Exercise class ☐ Yoga ☐
Swimming ☐ Weights gym ☐ Walking programme ☐

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

Suitable for Exercise Yes ☐ No ☐
Considering Bariatric Surgery? Yes ☐ No ☐

GP contact details

Name ....

Address ....

....

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 This scheme has been fully explained to me. I wish to decrease my current weight by participating in the scheme. I give my consent for any relevant clinical information about my health and participation on this scheme to be used for evaluation and monitoring purposes. I consent to my information being stored on a database for audit purposes (in accordance with the Data Protection Act 1977)

Name (PRINT)...

Signature ....

Date: ....

OFFICE USE ONLY

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

Date of first contact attempted:.. First date declined ☐

Date of first contact made (if different) .... Date of first appt ....