**Weight Management Service Referral Form**

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| **Customer Details** | |
| **Consent needs to be in place for a referral to be made. Has this been given?** | Choose an item. |
| **Date of Referral** |  |
| **Customer Surname** |  |
| **Customer Forename** |  |
| **Customer Address** |  |
| **Customer Postcode** |  |
| **Customer DOB** |  |
| **Customer Contact Telephone Number** |  |
| **\*\*Customer Contact E-mail address\*\***  **Please ask patient for this to complete on-line Questionnaire. Alternatively you may fill out with client. It will take 30 mins** [**https://forms.office.com/r/swc1xvmWJX**](https://forms.office.com/r/swc1xvmWJX) |  |
| **NHS Number** |  |
| **Referrer contact details (name, e-mail, telephone number)** |  |
| **GP Surgery Address** | Choose an item. |
| **Name of GP** |  |
| **Patient criteria to access the program** | * 26 BMI   18 years old and above |
| **Patients Weight (kg)** |  |
| **Height (cm)** |  |
| **BMI** |  |
| **Please provide overview of current medical conditions if any.** | |
| **Cannot access the program for the following reasons**   * Pregnant * Breast feeding * Diagnosed eating disorder * Underlying medical condition for obesity * Significant co-morbidity * Complex needs identified by the GP or healthcare professional | |

Please send this form to [betterhealthbetterself@chorley.gov.uk](mailto:betterhealthbetterself@chorley.gov.uk)