**Be Well Tameside Referral Form**

**Client details**

|  |  |  |  |
| --- | --- | --- | --- |
| Referrer’s Name |  | Date of referral |  |
| Service/GP/Practice/Ward/Dept |  | | |
| Contact number |  | Event attended (Internal only) |  |
| Patient/Client is aware of referral | Yes | | |

|  |
| --- |
| **Client interested in:** |
| Weight Management  Physical Activity  Stopping Smoking (Inc. e-cigs & paan/niche)  Alcohol Awareness  Healthy Eating  Other (please state below) |
| Any other relevant information: (health issues, language need, etc…) |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Title |  | Male 🗆 Female 🗆 | Telephone |  |
| Name |  | | Mobile |  |
| Address |  | | Best time to call |  |
| D.O.B. |  |
| Postcode |  | | BMI |  |
| Ethnicity |  | | Sexual Orientation |  |
| Surgery |  | | Dr’s Name |  |
| Does the client have a long term condition | | | Yes  No | |
| If yes please state: | | | | |
| Is the client being referred following an NHS Health Check | | | Yes  No | |

**For more information please contact Be Well Tameside**

Phone: **0161 716 2000** Fax **0161 716 2011**

Email: [bewelltameside@nhs.net](mailto:bewelltameside@nhs.net)

Any other relevant information: