REFERRAL FORM

Weight Management Programme

POSITIVE *Energy*

Contraindications: Please DO NOT REFER if the patient suffers from any of the following:

- BP ≥ 180/100mmHg
- Resting tachycardia (Parenthese ≥ 100 bpm)
- Uncontrolled atrial/ventricular arrhythmias
- Unstable or acute heart failure
- Febrile Illness
- Unstable Angina
- Unstable/untreated congestive cardiac failure
- Chest pains/shortness of breath at low levels of activity
- Active pericarditis or myocarditis
- Uncontrolled acute systematic illness
- Uncontrolled pathologies

Referrer Name:

Referrer Address:

Post Code:

Referrer Tel:

Referrer Email:

Regular GP:

Reason for referral:

☐ Obese BMI >30 ☐ Mental illness

☐ Learning dissability

Patient Weight: ☐ **Patient Height:** ☐

Patient BMI: ☐

Medical conditions/relevant information:

Current medication:

☐ Asthma ☐ Diabetes

☐ Anti-depressant ☐ Blood pressure

☐ Other (please specify)

REFERRER CONSENT:

I refer this patient to the Fusion Positive Energy Adult Weight Management Programme and confirm the participant is fit and able to participate.

Referrer Signature: **Date:**

Patient Name:

Address:

Post Code:

Tel:

Email:

DOB: Sex:

Ethnicity:

☐ White British ☐ White other

☐ Asian/Asian British ☐ Black/Black British

☐ Other

Language/s spoken:

Details of translator (if applicable)**:**

Preferred method of contact:

☐ Phone ☐ Email

☐ Text ☐ Post

PATIENT CONSENT:

☐ Patient understands they are taking part in a weight management programme

☐ Patient has agreed to have their information passed on to fusion lifestyle

Patient Signature: **Date:**

Please return completed form to afl@fusion-lifestyle.com