HEALTHIER TOGETHER HACKNEY

Please complete in BLOCK CAPITALS. **All items must be completed.**

1. Patient details	**Referrer details**
Name:	Name:
Date of birth: (over 18) Gender:	Profession / Department:
NHS number:	Organisation / Service:
Address:	Address:
Postcode:	Postcode:
Telephone (home):	Telephone :
Telephone (mobile):	Email address:
Email:	GP name (if not the referrer above):
Ethnicity:	Organisation/ Practice:
Occupation:	

2. Baseline Measurements (within the last 6 months)

*BP: Required BP < 180/100	*RHR: Required RHR < 100	*HT (cm):	*WGT (kg):	*BMI:	HbA1c: % Required HbA1c < 11%

3. Reason for Referral – Select at least one from the list below

Adult Weight Management Overweight – BMI ≥25 OR ≥23.5 BAME WITH other risk factors for type 2 diabetes or CVD (please tick below)	☐	Adult Weight Management Obese – BMI 30+ OR ≥27.5 BAME	☐	Physical Activity on Referral Classified as 'Inactive' <30min moderate activity per week WITH at least one established risk factor or (stable) chronic condition listed below.	☐

Please consult the **Full Inclusion and Exclusion Criteria overleaf.**

4. Other Medical Conditions (please tick all that apply and attach additional details if applicable)

CVD (not specialist)	☐	Osteo / Rheumatoid Arthritis	☐	Asthma / *COPD (*not specialist)	☐
High Cholesterol	☐	Fibromyalgia	☐	Anxiety / Depression (mild-mod)	☐
Pre-diabetes	☐	Cancer	☐	Peripheral Arterial disease	☐
Hypertension	☐	Chronic Fatigue Syndrome	☐		
Family history CVD Family history of diabetes	☐ ☐	Type 2 Diabetes (Controlled) HbA1c required Date of diagnosis ………….	☐	Type 1 Diabetes (Controlled) HbA1c required Date of diagnosis …………	☐

Other:

5. Current Medication (please attach prescription list/additional sheet)

6. Other Considerations

Does the patient have any special communication needs? please specify	No ☐ YES ☐……………………………………
Does the patient have a learning difficulty / disability please specify	No ☐ YES ☐…………………………………….
Does the patient have a physical mobility issue/ disability please specify	No ☐ YES ☐……………………………………

7. Referrer / Patient Consent

Sign/ tick below to confirm agreement of the following: **I am ready to participate in the programme** and agree for the information on this form to be passed on to the HTH team and for the service to request further clinical information from other health professionals if required. I agree for my data to be used for the purpose of service evaluation and to be later contacted for follow up.

Patient name: **Signature:** ☐ (tick if electronic)

Sign/ tick below to confirm agreement of the following: I have discussed the referral with this patient and I believe them to be **ready and suitable to participate** in the physical activity programme. The information on this form is an accurate representation of this patient's health status. The patient is clinically stable and compliant with medications. If I become aware that this status changes, I will endeavour to inform the HTH team.

Referrer Name: **Signature:** ☐ (tick if electronic)

Date:_____________________

Please ensure this form is completed and signed by both referrer and patient and then send to: FAX **087 2446 4680**
Email: CAHCCG.Healthwise@nhs.net, Post: King Hall Leisure Centre, 39 Lower Clapton Rd E5 0NU (0207 749 7645)

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Inclusion Criteria

<u>Participants must be:</u>

- Aged 18 years or over
- Hackney resident, or, if non Hackney resident, registered with a Hackney GP
- At least one of:
  - Obese OR overweight with obesity-related risk factors
  - Inactive (≤ 30 minutes physical activity per week) with risk factors/health conditions amenable to physical activity.
- Initial assessment suggests 'ready to change' and in need of a structured programme

Adult Weight Management Exclusion Criteria

<u>The patient must not have any of the following contraindications:</u>

- Pregnant or breastfeeding
- A diagnosed eating disorder
- Co-morbidity or underlying medical cause of obesity which requires medical intervention:
- Unstable/uncontrolled moderate/ severe mental health condition

Please note this is a group based programme

PARS Exclusion Criteria

<u>The patient must not have any of the following contraindications:</u>

- Need a rehabilitation exercise programme tailored to support recovery from specific conditions including; Cardiac, Stroke, Pulmonary Rehabilitation, Neuromuscular Disease.
- Unstable/uncontrolled moderate/severe mental health condition.
- Those with contraindications for exercise according to current British Association for Cardiovascular Prevention and Rehabilitation (BACPR) guidelines:

Please note:

Any referrals with an unstable and/or limiting physical or mental condition will be referred back to their GP to access specialist support, as appropriate.

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