

Patient details

Name	Title	Gender	Referral Date
NHS Number	Age	Tel	
Current Address	Mob		
	Email		
Does patient have caring responsibilities? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			

Referrer details

Referring Clinician	
Practice / organisation details	Tel
	Fax
GP details if referring organisation different	

Area of support required

<input type="checkbox"/> Emotional Wellbeing	<input type="checkbox"/> Healthy Lifestyles	<input type="checkbox"/> Physical Activities	<input type="checkbox"/> Social Networks
<input type="checkbox"/> Employment & Skills	<input type="checkbox"/> Welfare & Benefits	<input type="checkbox"/> Families & Parenting	<input type="checkbox"/> Domestic Violence

Patient risk assessment

Do we need to speak to a member of the practice team before making contact with the patient, for example if there is a history of aggressive behaviour? No Yes

Patient additional needs

Please tell us of any additional support needs, such as disability or language.

Physical activity only

We are unable to work with any patient who has had a heart attack in the last 6 months who has not completed a phase III Cardiac Rehabilitation Programme.

Blood pressure	Resting Heart Rate
----------------	--------------------

Exercise is contra-indicated for people with systolic BP above 180, diastolic above 100 or a resting heart rate above 100bpm.

Does the patient have any past or current medical conditions Eg. coronary heart disease, COPD, musuloskeletal, BMI over 30?

No Yes If yes enclose relevant medical history / medication. Advise of any conditions we should be aware of eg EpiPens, epilepsy, fainting/dizzy spells, asthma inhaler etc

I confirm that the patient's medical condition is stable.

Patient data protection

I confirm that the personal details on this form are correct. I consent to my personal details being passed to the relevant Zest services, approved referral partners (including feedback to my GP) and to be entered onto the NHS National Data Collection and Reporting System in accordance with the Data Protection Act 1998. I agree to be contacted using the contact details provided on this document to follow up this appointment and audit the service. I consent to anonymised data being passed to Sheffield City Council and others to provide service monitoring and reports). I agree to Zest sending me publicity information about services and activities.

Patient Signature	Date
-------------------	------

Return referral to

Jenny Hare
The Zest Centre
18 Upperthorpe
Sheffield S6 3NA
Tel: 0114 270 2040 ext 210
Email: jenny.hare@nhs.net
Fax: 0114 399 8004

GP Practice Stamp