

Healthy LIFE

Adult Referral Form

Completed referral form to be emailed to: leisure.bletchley@serco.com

Please tick that the patient has consented to this referral and for their details to be shared with More Leisure Community Trust ☐

Referrers Details:

Job Title: _____ Referrers Name: _____

Practice / Clinic: _____

Contact Number: _____ Date Referred: _____

Contact Email address: _____

Patient Details:

First Name: _____ Surname: _____ Gender: _____

Date of Birth: _____ Phone: _____

Address: _____ Post code: _____

Email Address: _____

Referral Reason – Tick all that apply

Participants must be **adults (18+)** who are currently inactive, have or are at risk of a long-term health condition, are taking medication as advised, and are motivated to increase physical activity.

Category / Risk	Condition			
Low Risk <input checked="" type="checkbox"/>	Overweight (BMI ~25)	<input type="checkbox"/> Type 2 diabetes (diet controlled)	<input type="checkbox"/> Mild osteoarthritis	<input type="checkbox"/>
	Mild asthma	<input type="checkbox"/> Mild depression, anxiety, or stress	<input type="checkbox"/> High-normal BP (130–139 / 85–89 mmHg)	<input type="checkbox"/>
	Mild musculoskeletal injuries	<input type="checkbox"/> Hypercholesterolemia	<input type="checkbox"/> Older adults (>65) with ≤2 CHD risk factors	<input type="checkbox"/>
	Antenatal (no complications) / Postnatal (after 6-week check)	<input type="checkbox"/> Cancer – in remission, medically stable or survivor	<input type="checkbox"/>	

Category / Risk	Condition					
Medium Risk <input checked="" type="checkbox"/>	Controlled Stage 1 hypertension	<input type="checkbox"/>	Osteoporosis (no fracture history)	<input type="checkbox"/>	Stable neurological conditions (stroke >1 yr ago, Parkinson's, MS)	<input type="checkbox"/>
	Controlled diabetes (Type 1 or 2)	<input type="checkbox"/>	COPD without ventilatory limitation	<input type="checkbox"/>	Moderate depression or anxiety	<input type="checkbox"/>
	Chronic fatigue / fibromyalgia (moderate)	<input type="checkbox"/>	Moderate osteoarthritis / rheumatoid arthritis	<input type="checkbox"/>		

Physical Referral Information:

Activity Level: ☐ Inactive ☐ Moderately Inactive ☐ Moderately Active ☐ Active **BMI:** _____

Current Medication: _____

Is there any additional information we should be aware of?

Consent:

☐ Patient consents to sharing information with Healthy Life Coach

Patient Signature: _____ **Date:** _____

Referrals Approval:

☐ I refer this patient to be able to take part in the Healthy Life program

Signature: _____ **Date:** _____