**DETAILS OF PROFESSIONAL COMPLETING FORM:** **PATIENT’S GP DETAILS:**

**Name: Name of GP:**

**Profession: Practice Name**

**Location: and Address: Telephone: Telephone:**

**Email: Email:**

**Patient Details**

Name:­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sex:  Male  Female  Other: *please specify*\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:

Tel (home): Tel (mobile): Email: f   
  
  
Disability: Ethnicity:

**Care coordinator / case worker / support worker:**

Name: Role: Organisation & address:

Contact Tel: Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact details** (e.g. next of kin, supported housing worker, etc)

Name: Relationship: Contact Tel:

**Please confirm that your patient does NOT meet any of the exclusion criteria  
Confirmed Yes**  **No**  (Please see overleaf for inclusion/exclusion criteria)

**Severe & enduring mental health diagnosis (please tick all appropriate)**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Mental Health** |  |  |  |  |  |  |  |  |  |  |
| Schizophrenia |  |  | Bi-polar |  | Severe clinical depression |  | Psychosis |  | Other (please state) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |

**Current Prescribed Medication**

Some medications may affect your patient’s ability to exercise and their response to exercise. Please list all medications, or attach a list of medication currently being prescribed. Include further details if necessary:

|  |
| --- |
|  |

**Patient Informed Consent**

I am aware that Enable Leisure & Culture and Mind in Brent, Wandsworth and Westminster will be obtaining details of my medical history from my GP as part of the initial assessment and during the course of the programme.

I agree to Enable Leisure & Culture and Mind in Brent, Wandsworth and Westminster obtaining my Risk Summary plan from my CMHT or support agency, if necessary, as part of the initial assessment and during the course of the programme.

I am aware that acceptance on the programme is subject to meeting the inclusion criteria and passing the initial assessment.

I agree for the above information to be disclosed to the exercise instructors. I understand that Enable Leisure & Culture will hold the information provided for the sole purpose of delivering, monitoring and evaluating the Active Wellbeing programme. It will not be used for any other purpose by them nor will it be disclosed to other departments, or any other person, except if there is significant concern for the safety and wellbeing of myself and others.

**Has the patient consented to the referral?** Please delete as appropriate. **Yes No**

Patient’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referrer’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Key expectations of participants joining the Active Wellbeing programme:

1. Able to communicate consistently and respectfully with their instructor, and our support team by telephone, email, or text message.
2. Committed and prepared to attending exercise sessions weekly. Each participant has 10 exercise sessions, these are most effective when completed within 12 weeks.
3. Ready to change their sedentary behaviour e.g. in the contemplation stage of behaviour change model.

|  |  |
| --- | --- |
| **Inclusion: Patient can be referred** | **Exclusion: Patient cannot be referred** |
| **1. Age**  Adults aged 18 years +  **2. Mental Health (severe mental illness only)**  ♦ Bi-Polar disorder  ♦ Severe clinical depression  ♦ Schizophrenia  ♦ Psychosis  **3. Location**  Living in or registered with a GP in Wandsworth | 1. Patients who considered to be moderately active (active for a total of 150 minutes per week), or already a member of a gym  2. Patients who have been diagnosed with heart disease (< 6 months), including all patients with unstable angina  3.We don’t accept referrals of individuals with a personality disorder, unless they have another severe & enduring mental illness alongside it  4. Patients under 18 years of age  5. Out of borough patients  6. Patients with no diagnosis of severe & enduring mental illness |

Please state the reason for the patient’s referral:

**SMI Physical Health Check Status**

|  |  |  |
| --- | --- | --- |
| **Measures** | **Score/Result** | **Date** |
| BMI + Waist Circumference |  |  |
| Blood Pressure + Pulse |  |  |
| Blood Lipid including Cholesterol |  |  |
| Blood glucose or HbA1c measurement |  |  |
| Assessment of alcohol consumption |  |  |
| Assessment of smoking status |  |  |
| Assessment on Physical Activity |  |  |

**Risk Assessment**

|  |  |  |
| --- | --- | --- |
| **Is there a history or risk of?** | **Yes/No** | **If yes, please provide as much detail as possible, including dates, etc** (use extra sheets if necessary) |
| Self-Harm |  |  |
| Substance Abuse |  |  |
| Self-Neglect |  |  |
| Harm to Others |  |  |
| Harm from Others |  |  |
| Any relevant criminal convictions or cases pending |  |  |