**Wellbeing for Life - Client Enquiry Form**

For Clients **aged 16+** who would like to access support for their health and wellbeing. Please email/scan completed form to: [cdda-tr.WBFL@nhs.net](mailto:cdda-tr.WBFL@nhs.net) or call 0800 8766887 for self- referral assistance

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| --- | --- | --- | --- | --- |
| **Is this a Self-Referral? Yes** ❑ **No** ❑If YES go to Q2, if **NO** it is **ESSENTIAL to complete Q1** | | | | |
| **1. Referrer Details: (a member of the Wellbeing team may contact you for more information)** | | | | |
| Name: |  | Tel No: |  | |
| Job Title: |  | Mobile: |  | |
| Organisation: |  | Email: |  | |
| Address: | | | | |
| I confirm the client has provided consent for this referral and understands the main reason for referral is:  Yes ❑ No ❑ Date | | | | |
| **2. Client Details:** | | | | |
| Surname: |  | First Name (s): | |  |
| Address: | | Preferred Name: | |  |
| DoB: | |  |
| Gender: | |  |
| Post Code: |  | Home No: | |  |
| Email: |  | Mobile No: | |  |
| Preferred method of contact: Phone ❑ Mobile ❑ Email ❑ Post ❑ | | | | |
| Best time to contact client: Day: Time: | | | | |
| Consent given to leave message on preferred number? Yes ❑ No ❑ | | | | |
| Client identifies as (*please state*): Unemployed ❑ Veteran ❑ Ex-offender/Probation ❑ Carer ❑ Gypsy, Roma & Traveller ❑ LGB&T ❑ Mental Health Condition ❑ LD ❑ | | | | |
| **3. Reason for Referral:** | | | | |
| Please indicate the primary reason(s) support is required (choose no more than 2 options) | | | | |
| ❑ Healthy Eating / Weight Management  ❑ Physical Activity  ❑ Improving Mental Wellbeing  ❑ Improving General Health & Wellbeing  ❑ Alcohol / Recreational Drug Use  ❑ Accessing Services & Groups in the Community | | | ❑ Stop Smoking  ❑ Support with Managed Long-term Health Condition  ❑ Accessing Volunteering  ❑ Accessing Further Learning / Improving Employability | |
| **Long term health conditions?** Yes ❑ No ❑  If ‘Yes’ please provide details e.g. diagnosis and effect on day to day life | | | | |
| **Are there any other professionals involved?** Yes ❑ No ❑  If ‘Yes’ please provide details | | | | |
| **Are there any known risks that the service should be aware of?** Yes ❑ No ❑  If ‘Yes’ please provide details | | | | |
| **Additional needs e.g. Audio / Visual Impairment / Literacy / Learning / Physical Disability:** | | | | |
| **4. G.P.** | | | | |
| GP Name: |  | Tel No: |  | |
| Practice Name and  Address: |  | | | |

\*\* The data you have provided will be entered into a database and will be securely stored in accordance with the Data Protection Act 1998/GDRP 2018 and our Policies and Procedures.