**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 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.