**Connected Communities Social Prescribing Service Referral Form**

|  |  |
| --- | --- |
| PATIENT NAME: | REFERRAL DATE: |
| Address: | NHS No.: |
| Telephone Number: | Date of Birth: |
| REFERRER NAME: | Gender: |
| REFERRER POSITION: | Ethnicity: |
| REFERRER EMAIL: | Is an interpreter needed? |
| ORGANISATION: | (If yes, please state language) |

|  |
| --- |
| IDENTIFIED NEED(S): |
| 🞎 Weight Management  🞎 Physical activity support  🞎 Healthy eating  🞎 Smoking, drugs, alcohol and other addictive behaviours  🞎 Anxiety/Stress/Depression/Low mood  🞎 Social Isolation  🞎 Learning/Training/Employment  🞎 Money/Debt/Benefits  🞎 Housing Issues  🞎 Bereavement  🞎 Carer  🞎 Other |
| 🞎 Frequent attender |
| REASON FOR REFERRAL: (include all relevant information including other agencies involved and state any health and safety risk) |
| IS THERE ANYTHING ELSE WE SHOULD KNOW PRIOR TO BOOKING A ONE-TO-ONE APPOINTMENT WITH THIS PERSON? |
| LONG TERM CONDITION/DISABILITY: |

🞎 I confirm that I have discussed this referral with the participant and have their permission to use and pass on to Connected Communities their contact details and relevant information about them for the purpose of arranging an appointment.