Connect for Health Referral Form

BSC Multicultural Services

PATIENT NAME:	REFERRAL DATE:
Address:	NHS No.:
Telephone Number:	Date of Birth:
REFERRER NAME:	Gender:
REFERRER POSITION:	Ethnicity:
REFERRER EMAIL:	Is an interpreter needed?
SURGERY/PRACTICE:	(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 I have discussed this referral with the patient and have their permission to pass on relevant health information about them.