**Service User Details**

**Champions Show the Way Referral Form**

**This form is for the referral of suitable service users to Community Health Champion-led activities, delivered by Champions Show the Way.**

**Referral Criteria**

* The service user must recently have been discharged from hospital and or have a long term condition.
* They must be independent enough to leave their own home un-aided
* They must be well enough to access an activity in the local community run by a volunteer.
* Where appropriate have GP approval to participate in a physical activity.
* The service user must be informed that the referral to Champions Show the Way is being made and that someone from the team will be getting in touch with them.

**Please post to:**

Champions Show the Way, Cottingley Surgery, 10 Canon Pinnington Mews, Cottingley, BD16 1AQ or

**Telephone:** 01274 321911 or **Fax:** 01274 322663

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **1. Title**  *(Mr, Mrs, Miss, Ms)* | | | |  | **2. Date of Birth** | | | | |  | | | | **3. NHS No** | | |  | | |
| **4. Name** | | | |  | | | | | | | | | | | | | | | |
| **5. Address**    *Postcode* | | | |  | | | | | | | | | | | | | | | |
| **6. Telephone** | | | |  | | | | | | | | | | | | | | | |
| **7. Email** | | | |  | | | | | | | | | | | | | | | |
| **8. First language?** | | | |  | | | | | **9. Any Communication issues?** | | | | | | | |  | | |
| **10. Has the patient been made aware that this referral is being made?** | | | | | | | | | | | | | | | | | * **Yes** | * **No** | |
| **11. Is the patient required to have permission to participate in physical activity?** | | | | | | | | | | | | | | | | | * **Yes** | * **No** | |
| **12. If yes do they have the appropriate permission?**    *By who?* | | | | | | | | | | | | | | | | | * **Yes** | * **No** | |
|  | | |
| **13. Does the patient have, or is the patient a carer?** | | | | | | | | | | | | | | | | | * **Yes** | * **No** | |
| ***DETAILS*** | |  | | | | | | | | | | | | | | | | | |
| **14. Has the patient been admitted, or had a stay in hospital, in the last 90 days** | | | | | | | | | | | | | | | | * **Yes** | | | * **No** |
| ***DETAILS*** |  | | | | | | | | | | | | | | | | | | |
| **15. Reason For referral?** | | | | | | | * **Relaxation** | | | | | * **Healthy Eating** | | | | | * **Isolation** | | |
| * **Increase physical activity** | | | | | | * **General Mental Wellbeing** | | | | | | | | | * **Other? *(please state below)*** | | | | |
|  | | | | | | | | | | | | | | | | | | | |
| **16.GP Practice** | | |  | | | | | | | | **Referrer Contact** | | | | | | | | |
| **NAME:** | | | | | | | | |
| **TEAM:** | | | | | | | | |
| **Tel:** | | | | | | | | |
| **17. Where did you hear about us** | | | **Eg Word of mouth, workplace, GP surgery, Library, leaflet** | | | | | | | | | | | | | | | | |
| **PLEASE TURN OVER** | | | | | | | | **Date of referral** | | | | |  | | | | | | |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **18.** **Gender**  Please help us measure the equality of our service by completing the following information *about the patient*. | |  | | |  | | | | |
| * Male | | * Female | | | * Unknown | | | | |
| **19. Age** | |  | | |  | | **For office use** | | |
| * under 20 | | * 41-50 | | | * 71-80 | | | * Did not disclose | |
| * 21 - 30 | | * 51-60 | | | * 81-90 | | | * No referral details | |
| * 31 - 40 | | * 61-70 | | | * 91+ | | | * Unable to contact | |
| **20. Do you have a long term condition or a disability as defined by the definition of a disability under the Equality Act 2010?** *PLEASE TICK ANY THAT ARE RELEVANT* | | | | | | | | | |
| * Yes | | | * No | | |  | | | |
| * Alzheimer’s | | | * Diabetes | | | * Parkinson’s | | | |
| * Asthma | | | * Epilepsy | | | * Skin condition | | | |
| * Back Problems | | | * Heart Condition | | | * Speech Impediment | | | |
| * Blood condition | | | * Learning Difficulties | | | * Visual Impairment | | | |
| * High Blood Pressure | | | * Lower Limb Disorder | | | * Other Long Term Condition – please state | | | |
| * Low Blood pressure | | | * Upper Limb Disorder | | |
| * Cancer | | | * Mental Health Issues | | |
| * COPD | | | * Multiple Sclerosis | | |
| * Deaf or hard of hearing | | | * Osteoarthritis | | |
| * Dementia | | | * Osteoporosis | | |
| **21. Do you have any allergies?** If yes, please state. | | | | | | | | | |
|  | | | | | | | | | |
| **22. Please describe your ethnic group** *(please tick one)* | | | | | |  | | |  |
| * White – British | | | | * Mixed - White & Asian | | | | | **For office use** |
| * White - Irish | | | | * Mixed - Any other mixed background | | | | | * Did not disclose |
| * White - Any other background | | | | * Asian or Asian British - Indian | | | | | * Unable to make contact |
| * White - Scottish | | | | * Asian or Asian British - Pakistani | | | | | * No referral details |
| * White - Welsh | | | | * Asian or Asian British - Bangladeshi | | | | |  |
| * White - Gypsy/Romany | | | | * Asian or Asian British - Any other | | | | |  |
| * Mixed - White & Black Caribbean | | | | * Black or Black British - Caribbean | | | | |  |
| * Mixed - White & Black African | | | | * Black or Black British - African | | | | |  |
| * East European – please state | | | | * Black or Black British - Any | | | | |  |
| * Other Ethnic Groups – please state | | | | |  |
| **23. Do you have a religion or Belief?** *(please tick one)* | | | |  | | | | |  |
|  | | | | | |
| * Atheism | | | * Hinduism | | | * Sikhism | | | |
| * Buddhism | | | * Islam | | | * Other (please specify) | | | |
| * Christianity | | | * Judaism | | | * None | | | |
| **24. Are you a veteran?** *(A Veteran is someone who has spent at least 1 day in the armed forces)* | | | | | | | | | |
| * Yes | * No | | | | | | | | |
| **25. Please describe your sexual orientation** *(please tick one)* | | | | | | | | | |
| * Heterosexual/straight | | | * Gay Women/Lesbian | | | * Choose not to disclose | | | |
| * Gay Man | | | * Bi Sexual | | |  | | | |