

# 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 give consent for the referral to Champions Show the Way and be informed that someone from the team will be getting in touch with them. The information provided will be used for the purpose of engaging the individual in CSTW activity, it will not be passed onto any other person unless the activity is run in partnership with another organisation, the service will retain the information securely for 2 years, the individual can remove their consent at any time by contacting CSTW.

**Please post to:**

Champions Show the Way, Cottingley Surgery, 10 Canon Pinnington Mews, Cottingley, BD16 1AQ or  
**Telephone:** 01274 321911 or **Fax:** 01274 215404

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

Please help us measure the equality of our service by completing the following information *about the patient*. Please confirm the patient has given consent for you to provide this information, the patient will not be at a disadvantage by not providing this information. Yes  No

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