# Contact & Referral Form

**Referrer details**

**Name:**

**Address:**

**Telephone no: Email:**

**Date of Referral:**

**Personal Details**

**First Name: Surname: Rio No:**

**Address (inc. Post Code):**

**Tel No: Date Of Birth:**

**Gender: NHS No:**

**G.P. Name, Address & Tel. No:**

**Emergency Contact Name & No:**

**Ethnicity: White:** British ( ) Irish ( ) Other ( )

**(*please tick)* Mixed**: White & Black Caribbean ( ) White & Black African ( ) White & Asian ( ) Other Mixed ( )

**Asian**: British ( ) Indian ( ) Pakistani ( ) Bangladeshi ( ) Other Asian ( )

**Black**: British ( ) Caribbean ( ) African ( ) Other ( )

**Other Ethnic Categories**: Chinese ( )

**Not stated** ( )

**Medical History:**

Do you have a history of any of the following?

|  |  |  |  |
| --- | --- | --- | --- |
| **Condition** | **Yes** | **If Yes, please provide details** | **Medication taken to address the condition** |
| Asthma |  |  |  |
| Blood Pressure Issues |  |  |  |
| Diabetes |  |  |  |
| Cardiac issues |  |  |  |
| Raised Cholesterol |  |  |  |

If Yes to any of the above, assessor should contact GP for further information

Has letter been sent to G.P. to advise of the referral? (Use standard letter) YES / NO

**Current Physical Health:**

**Do you smoke? YES / NO**

**If Yes to the above, how many cigarettes do you smoke a day?**

**Do you vape? YES / NO**

**Do you use alcohol? YES / NO**

**How often do you drink alcohol? Daily Twice a week Once a week Never**

**How many units do you normally consume each week?**

**Do you use any non-prescribed drugs / substances? YES / NO / DECLINED TO ANSWER**

**If yes, please answer what you use and how often.**

**How often do you currently participate in 30 minutes of physical activity a day per week?**

0 days 1 day 2 days 3 days 4 days 5 days 6 days 7 days

**Mental health diagnosis** **or emotional wellbeing issues:**

**Triggers for relapse:**

**Named Care Co-ordinator / named worker:**

**Name of RMO:**

**Current Medication:**

**Prescribed by:**

**Current Care Plan:**

**Risk Issues**:

(Please tick if applicable. If yes please explore further and ensure this is addressed in Risk Management Contingency Plan)

Arson 

Aggression 

Violence 

Inappropriate sexual behaviour 

Damage to property 

Weapons 

Self-harm 

Substance Misuse (please specify) 

Other (please provide details below)

**Risk Management Contingency Plan:**

Please return this form to Sonia Smith, Coping Through Football Project Coordinator

Email: [sonia.smith@nelft.nhs.uk](mailto:sonia.smith@nelft.nhs.uk)