BPL Health Professional Referral Form (V4)

To: BPL	Referral Date:

Patient Details		GP Details	
Forename:		**Referring GP:**	
Surname:		**Registered GP:**	
Date of Birth:		**Practice:**	
Gender: **Ethnicity:**			
Address:		**Telephone:**	
		Fax:	
		Practice code:	

Home Tel No:
Work Tel No:
Mobile Tel No:

Explicit patient consent is required to share details with the provider. Patient consent has been given: Yes ☐ No ☐

MEDICAL HISTORY

BMI:
Height:
Weight:
Waist measurement:

- **History**
  - Active Problems
  - Significant Past
  - Anticipated Procedure:
- **Current medication:**
  - Acute
  - Repeat
- **Blood Pressure: ${Last_5_BP_Readings}**
- **Alcohol Consumption:**
- **Smoking:**

Known allergies:

Patient requires a surgical procedure in a Get Fit First speciality : YES: ☐ NO: ☐

Speciality:

General Surgery	☐	Neurosurgery	☐
Cardiothoracic	☐	Plastic Surgery	☐
ENT	☐	Trauma & Orthopaedics (including MSK)	☐
Gynaecology	☐	Urology	☐

Patient meets Wellbeing Programme referral criteria AND is motivated to make a positive lifestyle change: YES: ☐ NO: ☐

Wellbeing Programme criteria:

BMI 25	☐	Controlled Type II Diabetes	☐
Controlled Asthma	☐	Hypercholesterolemia	☐
Obesity	☐	Mild Anxiety	☐
Mild Depression	☐	Mild Hypertension	☐
Stress	☐	Patients requiring non-urgent surgical procedure	☐

Please email completed referral form to bpl.hrs@nhs.net