**JUMPS4LIFE (Ages 4-16)**

**Tameside Family Weight Management Programme**

**Health Professional Referral Form**

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| **Client Information** | |
| Child’s Name: | |
| NHS No: | |
| Date of Birth: | Gender: |
| Parent/Guardian Name: | Relationship to child: |
| Home Phone: | Mobile Phone: |
| Email : | |
| Address (including postcode): | |
| Child’s School : | Year at School : |
| Weight ( kg): | Height ( cm) : |
| Is the parent/guardian aware and in agreement with the referral? Yes No | |

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| **Medical Information- please provide any relevant information which we need to aware of before the child starts a programme** |
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| **Referrer Information** | |
| Name: | Designation: |
| Address  Telephone number | |
| SignaBlue_Banner_A5[1]ture: | Date of referral: |

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| **GP Information** | |
| Name of doctor: | Practice Name: |
| Address (including postcode):  Telephone Number: | |

Please email this form to [childrenscommunitycentralbooking@tgh.nhs.uk](mailto:childrenscommunitycentralbooking@tgh.nhs.uk) . If you require further information please contact the Children’s Nutrition Team on 0161 366 2349/51.

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| **What is your ethnic group? Please tick one option that best describes your ethnic group or background** |
| * British or mixed British * Irish * Other White background * White and Black Caribbean * White and Black African * White and Asian * Other Mixed background * Indian or British Indian * Pakistani or British Pakistani * Bangladeshi or British Bangladeshi * Other Asian background * Caribbean * African * Other Black background * Chinese * Other * Ethnic category not stated |