**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 . 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
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