SHAPE PROGRAMME REFERRAL FORM

Please complete this form with as much detail as you can and provide supporting information where possible (e.g. attached documents).

Patient Details

Name | Responsible Team/Clinician

Gender M F | D.O.B / /

Ethnicity | NHS no

Address

Postcode

Contact no: Home | Mobile

GP Name and Address

Consent to Contact: Y N

Mental Health Diagnosis

Medication used to treat mental health:

Medication	Dose	Date started
Medication	Dose	Date started
Medication	Dose	Date started
Medication	Dose	Date started

Physical Health Diagnosis

Medication used to treat physical health:

Medication	Dose	Date started
Medication	Dose	Date started
Medication	Dose	Date started
Medication	Dose	Date started

Physical Health

Has a baseline physical health assessment been completed? Y N Date

(Please attach copy)

Are there any risks in relation to increasing physical exercise? Y N

If yes please provide details

Treatment

Patient Consent

I am aware of this referral to the SHAPE programme: Y N

I give consent for staff to disclose and discuss details and issues with family/carers or relevant professionals in relation to my physical health: Y N

Signature

Date

Person Completing this Form

Name

Job Title

Service/Locality

Signature Date

FOR SHAPE USE

Outcome

Actions Required

Individual Goals Identified