Serco Business

MORE Healthy LIFE

Adult Referral Form

Completed referral form to be emailed to: buckinghamshireleisure@serco.com

Please tick that the patient has consented to this referral and for their details to be shared with More Leisure Community Trust ☐

Referrers Details:

Job Title: _____ **Referrers Name:** _____

Practice / Clinic: _____

Contact Number: _____ **Date Referred:** _____

Contact Email address: _____

Patient Details:

First Name: _____ **Surname:** _____ **Gender:** _____

Date of Birth: _____ **Phone:** _____

Address: _____ **Post code:** _____

Email Address: _____

Referral Reason – Tick all that apply

Participants must be **adults (18+)** who are currently inactive, have or are at risk of a long-term health condition, are taking medication as advised, and are motivated to increase physical activity.

Category / Risk	Condition				
Low Risk ☑	Overweight (BMI ~25)	☐	Type 2 diabetes (diet controlled)	☐	Mild osteoarthritis ☐
	Mild asthma	☐	Mild depression, anxiety, or stress	☐	High-normal BP (130–139 / 85–89 mmHg) ☐
	Mild musculoskeletal injuries	☐	Hypercholesterolemia	☐	Older adults (>65) with ≤2 CHD risk factors ☐
	Antenatal (no complications) / Postnatal (after 6-week check)	☐	Cancer – in remission, medically stable or survivor	☐	

Category / Risk	Condition				
Medium Risk ☑	Controlled Stage 1 hypertension	☐	Osteoporosis (no fracture history)	☐	Stable neurological conditions (stroke >1 yr ago, Parkinson's, MS) ☐
	Controlled diabetes (Type 1 or 2)	☐	COPD without ventilatory limitation	☐	Moderate depression or anxiety ☐
	Chronic fatigue / fibromyalgia (moderate)	☐	Moderate osteoarthritis / rheumatoid arthritis	☐	

Physical Referral Information:

Activity Level: ☐ Inactive ☐ Moderately Inactive ☐ Moderately Active ☐ Active **BMI**: _____
Current Medication: _____
_____

Is there any additional information we should be aware of?
_____

Consent:

☐ Patient consents to sharing information with Healthy Life Coach

Patient Signature: _____**Date:** _____

Referrals Approval:

☐ I refer this patient to be able to take part in the Healthy Life program

Signature: _____ **Date:** _____