Cambridge Weight Referral Form

● Health Professionals/Self Referral ●

1. Please complete **ALL** compulsory fields ***(*)*** and
2. **EMAIL** the referral to **info@cambridgeweightplan.co.nz**
3. Notify your patient that they will be in touch within 5 working days of receiving this referral.

Referring Health Professional: Email/Phone:

Practice/DHB:

Postal Address:

Section 1 – Patient Details *

First Name: Click here to enter text. **Surname**: Click here to enter text.

Gender: ☐ Male ☐ Female **Date of Birth:** Click here to enter text.

Ethnicity: Click here to enter text. **NHI:** Click here to enter text.

Address: Click here to enter text.

Suburb: Click here to enter text. **Post Code** Click here to enter text.

Home Phone: Click here to enter text. **Mobile:** Click here to enter text. **Work:** Click here to enter text.

Section2 - Medical Conditions: * Please list all that may affect dietary intake

☐ **Diabetes** please classify……..

☐ Cardiovascular …….. ☐ Dyslipidaemia ☐ Hypertension

Other Medical Conditions and Medication:

Patient informed and consent provided: ☐

Weight : **kg**

Height : **cm**

BMI : **kg/m2**

Target weight / weight loss : **kg / %**

Other relevant information: Click here to enter text.

Section 3 – Consent and Signature *

Consent from patient: Click here to enter text.

Patient's GP: Click here to enter text.

Practice: Click here to enter text.

Referring Health Professional: **Date:** Click here to enter text.

By noting my name above, I confirm that I have explained the Cambridge Weight Process and the patient has consented for their details to be forwarded to CAMBRIDGE WEIGHT PLAN who will provide them with support and advice.