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

***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.*

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.