LongfieldWellbeing Services Referral FormA picture containing text, sign, night sky

Description automatically generated

Burleigh Lane, Minchinhampton, GL5 2PQ

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Referral forms are available to download from the Longfield website: www.longfield.org.uk

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| --- | --- | --- |
| **Date:** | **NHS No:** | **Referral taken by:** *(please print)* |
| Surname: Gender: | | Does Client consent to referral? Yes o No o  Consent to the sharing of data recorded at Longfield with any organisations that may care for the patient? (i.e NHS) Yes o No o  Consent to Longfield viewing data recorded at any other organisations that may care for the patient?  (i.e NHS) Yes o No o  Consent to be added to the mailing list to receive future Longfield Information? Yes o No o  Are you a: (please tick)  Patient o  Carer/ Family member o  Bereaved o |
| First Name: DOB: | |
| Address:  Postcode:  Tel:  Mobile:  Can we leave a message?  Will you accept withheld numbers?  Email address:  How did you hear about Longfield? | |
| **Is GP aware of referral** Yes ¨ No ¨  GP Name:  Surgery: | | **Name of referrer (please print)**  Job Title**:**  GP/Surgery or Hospital:  Contact No: |
| **Client Next of Kin/ Emergency Contact**  Name:  Address:  Postcode: Tel:  Relationship: | | **Primary Diagnosis:** |
| **Medical & Psychiatric History/ Treatments.** |
| What are you interested in accessing at Longfield Wellbeing Centre? If you are not sure, please tick triage (Please tick)  Complementary Therapies Counselling  Physiotherapy Bereavement Counselling  Living well with Fatigue & Breathlessness Group Stronger Together (Bereaved only)  Move More Programme Walk & Talk (Bereaved only)  Tai Chi Movements for wellbeing Family & Carers Support  Living Well Programme Carer’s café  Creative Group Bereavement Friendship Cafe  Relaxation Programme Fork & Talk  Being In Nature Bereavement Support Group  Introduction to Nordic Walking  Creative Writing  Mindsong Triage | | |
| **Is Transport Required?** Yes ¨ No ¨  **Mobility (Include any walking aids):**  **Volunteer transport information: (check any walking aids, any issues with parking, getting in and out of a normal car)** | | |
| **Any allergies or intolerances:** | | |
| **Any concerns of the client or family / carers, or other information relevant to this referral:** | | |