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| **Office use only:** | Date Received: |  |
| Referral No. |  |

**Health Improvement Team**

**REFERRAL FORM**

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| **Please tick reason for referral:** |
| General healthy eating/weight management |  | Weaning |  |
| Practical cooking, menu planning, shopping |  | Managing fussy eating, mealtimes |  |
| Other: Please state - |  |  |  |

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| **SECTION A** – **Referrer details**  |
| Name |  | Role |  |
| Telephone  |  | Email |  |
| Has the client/patient consented to this referral? [ ]  Yes [ ]  No |
| **Any other information:** |

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| **SECTION B: Part 1 – Details of the adult or the main parent/carer of the child being referred:** |
| Adult Name |  | D.O.B |  | Gender |  |
| Address |  | Postcode |  |
| Mobile No. |  | Home Tel. |  |
| Email |  | NHS No. |  |
| Preferred way of contact | [ ]  Letter [ ]  Email [ ]  Mobile [ ]  Landline [ ]  Other: Please State:  |
| GP |  | Other services involved |  |
| Health issues/allergies |  | Physical/learning disabilities |  |
| English spoken? Level? |  | Interpreter req? [ ] Y [ ] N Language:  |

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| **Part 2 – Details of any other adults being referred/involved:**  |
| Adult name | D.O.B | M/F | Health conditionsor allergies? | Physical orlearning disabilities? | Relation to main adult | NHS No. if known |
| 1.  |  |  |  |  |  |  |
| 2.  |  |  |  |  |  |  |

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| **Part 3 – Details of children being referred/involved:**  |
| Child name | D.O.B | M/F | Health conditionsor allergies? | Physical orlearning disabilities? | Relation to main adult | NHS No. if known |
| 1.  |  |  |  |  |  |  |
| 2.  |  |  |  |  |  |  |
| 3.  |  |  |  |  |  |  |
| 4.  |  |  |  |  |  |  |

**Please email referral to:** **HIT@boltonft.nhs.uk** For any advice/queries contact **01204 463175**

For Office Use Only

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| **Date** | **Time** | **Notes** | **Signature** |
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