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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 conditions  or allergies? | Physical or  learning 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 conditions  or allergies? | Physical or  learning disabilities? | Relation to main adult | NHS No. if known |
| 1. |  |  |  |  |  |  |
| 2. |  |  |  |  |  |  |
| 3. |  |  |  |  |  |  |
| 4. |  |  |  |  |  |  |

**Please email referral to:** [**HIT@boltonft.nhs.uk**](mailto: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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