A close up of a sign

Description automatically generatedMORELIFE

REFERRAL FORM

Please complete the details below to refer your child or a patient to one of our FREE services. Once the form has been completed, please email it to our secure inbox

[beds-mk@more-life.co.uk](mailto:beds-mk@more-life.co.uk) and our friendly team will be in touch as soon as possible.

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Referral Source details** | | | | | | | | | | | |
| Referrers Name: | | |  | | | | | | | | |
| Organisation details/ relationship to the referred person: | | | | | |  | | | | | |
| Referrer’s Email: | | |  | | Date of referral: | | | | |  | |
| **Details of Referred Person** | | | | | | | | | | | |
| Title: | |  | | Date of birth: | | |  | | | | |
| First name: | |  | | Gender: | | | Male  Female | | | | |
| Surname: | |  | | Patient preferred contact number: | | | | | | |  |
| Patient Address: |  | | |  | | | | |  | | |
| Postcode: | |  | | Does the patient speak English? | | | | | | | Yes  No |
| **Email address**: | | | |  | | | |  | | | |
| Is the patient being referred currently pregnant? | | | | Yes  No | | | |  | | | |
|  | | | |  | | | |  | | | |

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| --- | --- | --- | --- | --- | --- |
| **Current Medical Information** | | | | | |
| Height (m): |  | Weight (kg): |  | BMI: |  |
| Select the required service: Adult Weight Management  Young People and Family Service | | | | | |

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| **I/ the patient consent to someone from the MoreLife team contacting them via (please tick boxes):** |
| Telephone |
| Email |
| Post |
| Please be aware that if you have not selected one of the boxes above, we are unable to make contact with you. If you would prefer we did not contact you using any of these methods, please contact us by calling our team on  0808 208 2340 instead. |
| I am happy for a voicemail to be left if I do not answer my phone (tick box): |

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| Use this area to supply further information if necessary: |
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| **Exclusion Criteria**  Please ensure referred persons meet the eligibility criteria which can be found on our website.  Please note patients will be excluded if they: |
| Have an eating disorder |
| Have an underlying medical cause for obesity and would benefit from more intensive clinical management than a Tier 2 service |
| Have significant complex or unstable co-morbidity, or have complex needs requiring specialist support, as identified by their GP or other healthcare professionals |
| Not a resident in Bedford Borough, Central Bedfordshire or Milton Keynes |

Please email to [beds-mk@more-life.co.uk](mailto:beds-mk@more-life.co.uk) or return via post to: MoreLife (UK) Ltd, Acorn House, Midsummer Boulevard, Milton Keynes, MK9 3HP