Referrer details		
Name		
Address		
Telephone no	Email	
Date of Referral		
Personal Details		
First Name Surname		
Address		Post Code
Tel NoDate Of Birth	Sex	NHS No:

G.P. Name, Address & Tel. No:....

.....Emergency Contact No.....

 Ethnicity:
 White: British () Irish () Other ()

 (please tick)
 Mixed: White & Black Caribbean() White & Black African() White & Asian() Other Mixed ()

 Asian/British Asian: Indian ()
 Pakistani () Bangladeshi () Other Asian ()

 Black:
 Caribbean () African () Other ()

 Other Ethnic Categories:
 Chinese ()

 Not stated ()
 Not stated ()

Medical History:

Do you have a history of any of the following?

Condition	Yes	If Yes, please provide details	Medication taken to address the condition
Asthma			
Blood Pressure Issues			
Diabetes			
Cardiac issues			
Raised Cholesterol			

If Yes to any of the above, assessor should contact GP for further information

Has letter been sent to G.P. to advise of the referral? (use standard letter)	YES /	NO
Are there any psychiatric side affects that might prohibit participation in phys	sical activity	YES / NO

Current Physical Health:	Current	Physical	Health:
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Baseline Obs:	Date checked:
Pulse	BP
Weight	Height
ВМІ	
Are you a Smoker YES/NO	
If Yes to the above, how many a day	
Do you use any illicit drugs? YES/ NO / DEC	
If yes please answer what drugs used and h	
n yes please answer what drugs used and h	now often.
Do you use alcohol? YES /	/ NO
How often do you drink alcohol? Daily	v Twice a week Once a week Never
How much do you normally consume on eac	ach occasion?
How often do you currently participate in 30	0 minutes of physical activity a day per week?
0 days 1 day 2 days 3 day	ays 4 days 5 days 6 days 7 days
Mental Health Diagnosis:	
Triggers for Relapse:	
Named Care Co-ordinator:	
Name of RMO:	
Current Medication:	
Prescribed by:	
Current Care Plan:	

Risk Issues : (Please tick if applicable. If yes please	e explore further and ensure this is addressed in Management Plan)
Arson Aggression Violence Inappropriate sexual behaviour Damage to property Weapons	
Self harm	
Substance Misuse (please specify)	
Other (please provide details)	
L	
Risk Management Contingency Plan	n:

Date of Assessment:

Letter sent: YES / NO

Please return this form to Sonia Smith:

- Address: Sonia Smith, Waltham Forest Access & Assessment Team, Coping Through Football Project Co-ordinator, 26 Low Hall Lane, Walthamstow, E17 8BE
- Email: sonia.smith@nelft.nhs.uk