HEALTH W.I.S.E.

PATIENT'S COPY - WHITE
HFDO COPY - YELLOW
G.P. COPY - BLUE

Patient's Name.....

Address.....

.....Post Code.....

Telephone number.....

Date of birth..... Gender: male / female

Blood Pressure	Resting Pulse
Height/Weight	BMI/Waist circumference
Bloods (Essential for one to one dietetic referral)	
Reason for referral	
Relevant Medical History	
Current Medication	

I RECOMMEND THAT THIS PATIENT IS A SUITABLE CANDIDATE FOR THE LIFESTYLE CHANGE PROGRAMME

Signature .....(G.P./Practice Nurse) G.P. Stamp

Date.....