ADULT WEIGHT MANAGEMENT AND TYPE 2 DIABETES PREVENTION SERVICE

SELF-REFERRAL FORM

Please complete all the boxes in the referral form below as fully as possible.

The referral form should then be sent to the **Adult Weight Management and Type 2 Diabetes Prevention Service** (address below) who will process and contact you in due course. If you have any queries about your referral, please contact the Service direct on 01383 674086.

FORENAME	
SURNAME	
TITLE	
10 DIGIT CHI NUMBER	**(This is your personal number that starts with your date of birth; you can find it on letters received from Health Care Providers.)**
DATE OF BIRTH	
GENDER	
ADDRESS	
POSTCODE	
TELEPHONE No.	
EMAIL ADDRESS	
GP PRACTICE AND ADDRESS	
REASON FOR YOUR REFERRAL **HOW CAN WE ASSIST YOU?**	

WHAT IS YOUR CURRENT WEIGHT?	
WHAT IS YOUR HEIGHT?	
MEDICAL HISTORY **Please include ill health problems you have had in the past (diabetes, high blood pressure, arthritis etc)**	
WHAT MEDICATION ARE YOUR TAKING?	
WHAT IS YOUR FIRST LANGUAGE?	
DO YOU REQUIRE US TO ARRANGE A TRANSLATOR?	YES/NO
PLEASE SUPPLY ANY OTHER HELPFUL INFORMATION	

WHAT TO DO NEXT

Please post this form to: **Adult Weight Management and Type 2 Diabetes Prevention Service**, Level One, Queen Margaret Hospital, Whitefield Road, Dunfermline, KY12 0SU. If you haven't heard from us within 4 weeks, please contact us on 01383 674086.

By submitting this form, you consent to us processing your data for referral purposes.