**ExWell Medical Programme Referral Form**

**The ExWell Medical team will contact the patient to arrange an induction / assessment session**

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| **PATIENT DETAILS** |
| PATIENT NAME  |  |
| DATE OF BIRTH: |  |
| HOME ADDRESS |  |
| PATIENT/FAMILY EMAIL | Mob: | Land: |
| NEXT OF KIN NAME:NEXT OF KIN CONTACT NUMBER: |
| **MEDICAL CARER DETAILS** |
| **CONSULTANT NAME** |  |
| HOSPITAL / CLINIC  |  |
| CONTACTS | Tel: | email: |
|  |
| **GP NAME** |  |
| ADDRESS |  |
| CONTACTS | Tel: | Healthmail/email: |
| **MEDICAL DETAILS** |
| MAIN DIAGNOSIS |  |
| STAGING (IF CANCER) |  |
| CO-MORBIDITIES |  |  |
| MEDICATIONS |  |  |

**SIGNED: DATE:**

**Contact Tel: Contact Email**