**ExWell Medical Programme Referral Form**

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **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**