

## Lifestyle, Eating & Activity for Families (LEAF)

Please send to: The Children's Weight Management Team  
 Child Health, Dolphin House, Gloweth,  
 Truro, TR1 3XQ

Email: [rcht.leaf.programme@nhs.net](mailto:rcht.leaf.programme@nhs.net)

Tel: 01872 253886

Date of referral: \_\_\_\_\_

Name, Profession and contact details of referrer: \_\_\_\_\_

### Client details

Surname: \_\_\_\_\_ Forename(s): \_\_\_\_\_

Date of birth:        /        /        Sex: M / F        NHS No.: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone number: \_\_\_\_\_ E-mail: \_\_\_\_\_ Mobile: \_\_\_\_\_

Parent / Carers details: \_\_\_\_\_ GP: \_\_\_\_\_

Parental responsibility: \_\_\_\_\_

First language : \_\_\_\_\_ Interpreter required: Y / N

Social worker: Y / N        Name and contact details: \_\_\_\_\_

Other professionals / agencies involved: \_\_\_\_\_

Risk / health and safety issues: \_\_\_\_\_

Ready to change: Y / N        Parental Consent: Y / N

### Growth history

Weight: \_\_\_\_\_ Kg    on    /    /        Weight: \_\_\_\_\_ Kg    on    /    /

Height: \_\_\_\_\_ cm    on    /    /        Height: \_\_\_\_\_ cm    on    /    /

BMI: \_\_\_\_\_ Kg/m<sup>2</sup>    on    /    /        BMI: \_\_\_\_\_ Kg/m<sup>2</sup>    on    /    /

### Summary of intervention already trialled


**Print**

**Sign**

**Date**

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affix patient label

### Family history

### Medical history (e.g diagnosis / cause for concern:

### Other comments

Print	Sign	Date

### Outcome - For official use only

Date referral received:    /    /

Outcome:

Print	Sign	Date