

Fields marked with \* are mandatory. Please send the completed form to the NSW Get Healthy Service by:  
**Email: [contact@gethealthynsw.com.au](mailto:contact@gethealthynsw.com.au) or Fax: 1300 013 242. For more information call: 1300 806 258**

<b>Health Professional Details</b> (Please print or stamp)			<b>Practice stamp</b>
Name* _____			
Profession* _____			
Organisation/Hospital* _____			
Postcode* _____		Phone Number* _____	
Email* _____			
<b>Feedback Letters</b> All feedback letters will be sent to the above email address.			
If you require feedback letters via post, please provide your postal address:			
_____			
Please tick if you do not wish to receive feedback letters <input type="checkbox"/>			
<b>Participant details</b> (Please print or affix patient sticker)			
Name* _____		Alt. Phone Number _____	
Date of Birth* _____		Postcode* _____	
Phone Number* _____		<b>Aboriginal and / or Torres Strait Islander origin?</b> *	
Email _____		No <input type="checkbox"/>	
Address _____		Yes, Aboriginal <input type="checkbox"/>	
Suburb _____		Yes, Torres Strait Islander <input type="checkbox"/>	
State _____		Yes, both Aboriginal and Torres Strait Islander <input type="checkbox"/>	
PCode _____		<b>Is your patient pregnant?</b> *	
<b>Is an Interpreter required?</b> * No <input type="checkbox"/> Yes <input type="checkbox"/>		No <input type="checkbox"/> Yes <input type="checkbox"/>	
Language: _____		Preferred call time: AM <input type="checkbox"/> PM <input type="checkbox"/>	
<i>The Service will call your participant within 5 working days upon receipt of a completed referral. If a mobile phone number has been provided on this referral form, your participant will receive a welcome SMS ahead of this call.</i>			
<b>Primary Reason for Referral</b> (Please tick one)			
<input type="checkbox"/> Weight Management	<input type="checkbox"/> Healthy Eating	<input type="checkbox"/> Alcohol Reduction	
<input type="checkbox"/> Physical Activity	<input type="checkbox"/> Diabetes Prevention	<input type="checkbox"/> Alcohol Abstinence in Pregnancy	
<b>Current body measurements:</b> (Optional)			
Waist Circumference (cm) _____		Weight (kg) _____	Height (cm) _____
If pregnant: Pre-pregnancy weight (kg): _____		Gestational age (wks): _____	
<b>General Comments</b> Please describe any health condition(s)/impairment which may have an impact on what the participant eats and drinks or their physical activity.			

Date Sent: \_\_\_\_\_



**Consent confirmation:** By submitting this completed form, the health professional / medical practitioner confirms that the participant has consented to this information being sent to the Get Healthy Information and Coaching Service, and consents for the Service to contact them (verbal consent is sufficient).

