PROACTIVE CARE TEAM

Holderness Health

The Proactive Care Team are here to listen and provide support!

Practical Support

Do you need help with your medication, have any concerns about caring issues either for yourself or someone you are caring for, falling or worried about your memory?

Physical Health and Social Activity

Do you need help with weight management, reducing/stopping smoking, reducing/stopping alcohol or substance misuse? Do you want to connect with social activity groups in the area?

Emotional Wellbeing

Are you feeling isolated and alone, unable to express your feelings or feeling down? Do you need support with a bereavement or would like some motivational coaching?

Social Advice

Do you need advice and help with getting carer support, have housing issues or need financial support with debts or benefits? Would you like some tips on saving energy at home?

You don't need to speak to a doctor to be referred - you can easily refer yourself by emailing or calling us on -

Email: hnyicb-ery.proactivecareteam.holdernesshealth@nhs.net
Phone: 01964 608202 / 0333 332 4242
Website: https://www.holdernesshealth.nhs.uk

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Social Prescribing/Health and Wellbeing Coach Patient Referral Form
Please send this form to our secure email address or drop-off at any of our surgeries, for the attention of the Proactive Care Team

hnyicb-ery.proactivecareteam.holdernesshealth@nhs.net

Date of referral:							
Referrals Must be Over 18 Years of Age and a Patient of Holderness Health							
Title (Mr/Mrs etc)		First Name(s)		Surname			
Address							
		Postcode					
Telephone no.		Mobile no.					
Email address							
Date of birth		NHS no. if known?					
Gender		Ethnicity					
Are there any risks at your home? People? Pets? Household hazards?	Yes		No		If yes, please provide detail:		
Do you have any long-term health issues?							
Are you accessing any other services we should know about? (e.g., district nurse)							
Do you require an interpreter?	Yes		No		If yes, for which language?		
If you are filling in this form for someone else, please confirm they agree to their details being shared with us and provide us with your contact details.					Yes		No

In what area(s) does you want help? (please tick)									
Physical health		Mental health / wellbeing		Social isolation		Lifestyle change		Self-care/ management of LT condition	
Benefits / social care advice		Other financial advice		Work		Training & learning		other	

What outcome would you like from this referral, what would you like to change?
Other information you think we need to know e.g. housing, finance, bereavement, drug misuse, communication needs etc.
Contact details if you are filling this form in on behalf of someone else **Name** **Address**   **Contact telephone number**