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|  | iCan Referral Form |  |  |
|  | This form is for professional use when referring a person to the services of iCan Wellbeing Group CIO.  Once complete please send the referral form to: [admin@icanwellbeing.co.uk](mailto:admin@icanwellbeing.co.uk) this is a secure mailbox  or post to:  iCan Wellbeing Group CIO, Unit 17 and 18 The Maltings, Bridge Street, Carlisle, Cumbria, CA2 5SR  For more information, please call 01228 819101  **We are a friendly charity (CIO) providing a safe environment for exercise, health, and wellness, encouraging interaction with likeminded peers.**  Please tick the box for the services you wish to prescribe the patient into, you may tick more than one box if appropriate:  **iCan Fitness- membership options available.**  Female only Fitness  Male only Fitness  Mixed Gender Fitness  **iCan Wellness- most services FREE of charge.**  Art for Wellbeing  Finding Your Purpose- 6-week course  Holistic Wellbeing  Living with and Beyond Cancer (peer to peer support)  Social Activities for Dementia (mild to moderate Dementia only)  Walk to Talk  Persistent pain peer to peer support group  Women’s Peer Support  **6 months free fitness programme\***  Patient affected by cost-of-living crisis and living on Low Income  Patient Has a mental health condition or experiencing mental health illness  Patient is awaiting surgery or on a long NHS waiting list for physical ailment  **\***To be eligible for a Free 6-month membership, the patient must be able to answer yes to at least one of the above options. This is thanks to National Lottery Community Funding.  The referred person will be triaged to the right department and an iCan team member will phone the referee directly. They will be offered a Free 3 Day Pass for the gym and and/or invited into the appropriate sessions with the aim of achieving physical and mental fitness at an affordable price or Free where some of our sessions are funded.  Referral membership is £22.50 per month discounted from £32.50- Unless eligible for the free fitness sessions. | |  |
|  | |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  | | | |  |  | | | | | | Date | | | |  | Referrer Name | | | | |  | | | |  |  | | | | | Phone number | | | |  | Organisation/company | | | | | Referral Information | | | | | | | | | |  | | | | | | | | | | Referral Name |  | | Phone Number | | |  | | Email Address | |  | |  | | | | |  | | |  | | | | | | | | | | Address | | | | | | | | | |  |  | |  | | |  | |  | | City |  | | County | | |  | | Postcode | |  | | | | | | | | | |  | | | | | | | | | | Reason For referral and any known health conditions including mental health. | | | |  | Date of Birth | | | | |  | | | |  |  | | | | |  | | | |  |  | | | | |  | | | |  |  | | | | |  | | | |  |  | | | | |  | | | |  |  | | | | |  | | | |  |  | | | | | Any other notes: | | | |  |  | | | | | |  |