**Weight Loss Group Enquiry Form**

**SEND COMPLETED FORM TO:** [worcscab.socialprescribing@nhs.net](mailto:worcscab.socialprescribing@nhs.net)

|  |  |
| --- | --- |
| Date: |  |
| **Your Details** | |
| Your name: | |
| DOB: | Gender: |
| Address: | |
| Post Code: | Telephone No: |
| Email: | Mobile: |
| Ethnicity: |  |
| Any additional Needs (*Mental Ill Health, Disability etc*): | |
|  | |
|  | |
| Please outline any long-term medical condition or disability: | |
| Is there anything else that we should know ? | |

**Signature: Date:**

**Postal address:**  Malvern Citizens Advice 52 Prospect Close Malvern WR14 2FD

**Data Protection and Consent**

When we record and use your personal information we:

● only access it when we have a good reason

● only share what is necessary and relevant

● don’t sell it to commercial organisations

We need to record information about you to help with your enquiry. We have a legitimate interest to do this. Please let us know if you’d like more information about how we’ll use your data.