Shape

Description automatically generated with medium confidence

**Hull Tier 3 Specialist Weight Management Services**

**Referral Form**

**Incomplete forms may be returned resulting in delayed assessment**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **PATIENT DETAILS:** | | | | | | | |
| Title: | Forename: | | | Surname: | | | Known as: |
| Date of Birth: | | | | NHS Number: | | | |
| Gender: | | | | Ethnicity: | | | |
| Religion: | | | |
| Address: | | | | | | | |
| Patient Home Telephone Number: | | | | Patient Mobile Number: | | | |
| Preferred contact number: Home  Mobile | | | | Email address: | | | |
| Name of Parent/Carer (children): | | | | Contact Number of Parent/Carer: | | | |
| Consent to contact via SMS: Yes | | | | Consent to contact via Email: Yes | | | |
| Consent to share medical information: | | | | Yes | | No | |
| **GP DETAILS:** | | | | | | | |
| Registered GP: | | | | GP Practice Address/ code / other contact details: | | | |
| Telephone Number: | | | |
| **REFERRER DETAILS if different from GP:** | | | | | | | |
| Name of Referrer: | | | | Address / contact number/email: | | | |
| Job Title: | | | |
| Date of referral: | | | |
| **SUPPORTING INFORMATION:** | | | |  | | | |
| Translator required: | | Yes | No | Language required: | | | |
| Accessible information needs: | | Yes | No | Detail needs: | | | |
| Reasonable Adjustment needs: | | Yes | No | Detail needs: | | | |
| Is there a lone working risk? | | Yes | No | Detail risk: | | | |
| Is there a Safeguarding Risk? | | Yes | No | Detail risk: | | | |
| Is the patient / carer aware of the referral? | | | | Yes | No | | |
| Any concerns re Mental Capacity? | | | | Yes | No | | |
| **ReSPECT** document in place? | | Yes | No | **If yes give details:** | | | |
| **REASON FOR REFERRAL / CLINICAL REQUEST / REFERRAL INFORMATION:** | | | | | | | |
|  | | | | | | | |
| **MEDICAL HISTORY:** | | | | | | | |
|  | | | | | | | |
| **SOCIAL INFORMATION:** | | | | | | | |
|  | | | | | | | |
| **ESSENTIAL INFORMATION** | | | | | | | |
| **Adults** | | | | **Children** | | | |
| Weight (kg): | | | | Weight (kg) – with centile: | | | |
| Height (m): | | | | Height (m) – with centile: | | | |
| BMI (Kg/m2): | | | | BMI Centile: | | | |
| **COMORBIDITIES** | | | | | | | |
| **Hypertension** | | | | Yes | No | | |
| **Type 2 Diabetes** | | | | Yes | No | | |
| **PCOS** | | | | Yes | No | | |
| **Asthma** | | | | Yes | No | | |
| **CHD/CVD** | | | | Yes | No | | |
| **Obstructive Sleep Apnoea** | | | | Yes | No | | |
| **Stroke / TIA** | | | | Yes | No | | |
| **Musculoskeletal** | | | | Yes | No | | |
| **COPD** | | | | Yes | No | | |
|  | | | | | | | |
| **Completed referral forms will be accepted via email to:** [**chcp.247111@nhs.net**](mailto:chcp.247111@nhs.net)  Telephone contact for queries: **01482 580200** | | | | | | | |

\* **Please note it is CHCP Policy that a family member or friend cannot be used for translation purposes\***