

**Hull Tier 3 Specialist Weight Management Services**

**Referral Form**

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

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| **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**Telephone contact for queries: **01482 580200** |

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