Shape

Description automatically generated with medium confidence

**Tier 3 Specialist Weight Management Services**

**Referral Form**

**\*Please Note: Incomplete forms will be returned, resulting on delayed assessment\***

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Name of Referrer: | | | | | Date of Referral: | | | | |
| Job Title: | | | | | | | | | |
| Address & contact number/email: | | | | | | | | | |
| **PATIENT DETAILS** | | | | | | | | | |
| Registered GP: | | | | | GP Practice Address: | | | | |
| Title: | Forename: | | | | Surname: | | | Known as: | |
| Date of Birth: | | | | | NHS Number: | | | | |
| Gender: | | | | | Ethnicity: | | | | |
| Address: | | | | | | | | | |
| Patient Home Telephone Number: | | | | | Patient Mobile Number: | | | | |
| Preferred contact number: Home  Mobile | | | | | Email address: | | | | |
| Name of Carer/Parent (children): | | | | | Contact Number of Carer/Parent: | | | | |
| Consent to contact via SMS | | | | | Yes | | No | | |
| Consent to contact via Email | | | | | Yes | | No | | |
| Consent to share medical information: | | | | | Yes | | No | | |
| Translator required: | | | Yes | | No | | Language required\*: | | |
| Chaperone required: | | | | | Yes | | No | | |
| Accessible information needs: | | | | Yes | No | | Detail needs: | | |
| Diagnosis: | | | | | | | | | |
| Are there any other services involved in patient’s care? | | | | | Yes | No | | | Don’t know |
| **(If yes give details)** | | | | | | | | | |
| **SUPPORTING INFORMATION** | | | | | | | | | |
| Is there a Lone working risk? | | | | | Yes | | No | | |
| Is there a Safeguarding risk? | | | | | Yes | | No | | |
| Has the patient given consent for the referral? | | | | | Yes | | No | | |
| Any concerns re Mental Capacity? | | | | | Yes | | No | | |
| **ReSPECT** document in place? | | | | | Yes | | No | | |
| **(If yes give details)** | | | | | | | | | |
| Smoking: | | Yes | | | No | | Don’t know | | |
| **ESSENTIAL INFORMATION** | | | | | | | | | |
| **Adults** | | | | | **Children** | | | | |
| Weight (kg): | | | | | Weight – with centile: | | | | |
| Height (m): | | | | | Height – with centile: | | | | |
| BMI (Kg/m2): | | | | | BMI Centile: | | | | |
| BP (mmHg): | | | | |  | | | | |
| Resting Pulse Rate (BPM) | | | | |  | | | | |
| **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 | | |
| **Has the patient been referred with Sleep Apnoea?** | | | | | Yes | | No | | |
| **If No Epworth Sleepiness Score documented, please enter score here:** | | | | | | |  | | |
| **Mandatory** **Blood Test Results** (Adult only) | | | | | | | | | |
| HbA1c (mmol/mol): | | | | | Full Blood Count: | | | | |
| Biochemical Profile: | | | | | B12 (ng/L): | | | | |
| Folate (ug/L): | | | | | Ferritin (ug/L): | | | | |
| Thyroid Function (TSH mu/L/freeT4 pmol/L): | | | | |  | | | | |
| **MEDICAL HISTORY – (Including Medication)** | | | | | | | | | |
|  | | | | | | | | | |
| **SOCIAL INFORMATION** | | | | | | | | | |
|  | | | | | | | | | |
| **REASON FOR REFERRAL** | | | | | | | | | |
|  | | | | | | | | | |

**To make a referral please send via email to:** [**chcp.247111@nhs.net**](mailto:CHCP.247111@nhs.net) **or contact Tel – 01482 247111**

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