

**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** **or contact Tel – 01482 247111**

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