SPECIALIST WEIGHT MANAGEMENT SERVICE REFERRAL FORM

Please complete all sections of this referral from and send to the Specialist Weight Management Service, Beacon House, Gloucestershire Royal Hospital

PATIENT DETAILS

Title	Mr/Mrs/Ms/Other …….	NHS number	
Surname		First Name	
Address *Or NHS sticker*		Postcode	
Contact Tel. No		Permission to leave message?	Yes ☐ No ☐
Date of Birth		Gender	Male ☐ Female ☐
Ethnicity		Disability	

GP DETAILS

GP name		GP Surgery		Telephone	

INFORMATION RELEVANT TO INCLUSION CRITERIA AND TREATMENT:

Weight:	kg	**Height:**	m	**BMI:**	kg/m²	**Date measured:**	

Please tick all conditions that apply:

(Alternatively, the information requested here can be provided as a printout of medical history)

☐ Diabetes: ☐ Type 1 ☐ Type 2 ☐ Gestational

Diabetes treatment: ☐ Diet ☐ Oral hypoglycaemic agents ☐ GLP-1 analogue ☐ Insulin

☐ Impaired glucose tolerance

☐ Hypertension

☐ Sleep apnoea ☐ Other respiratory problems (Please specify: ……..……)

☐ Intracranial Hypertension

☐ Polycystic Ovarian Syndrome (PCOS)

☐ Other known endocrine condition (Please specify: ……..……)

☐ Musculoskeletal problems (Please specify……...)

OTHER RELEVANT PHYSICAL HEALTH INFORMATION:

☐ Refusal of surgery due to weight (if so, please specify the procedure……..)

☐ Smoker ☐ Ex-smoker ☐ Non-smoker

☐ Drinks alcohol ☐ History of alcohol dependency ☐ Known to exceed recommended alcohol limit

☐ Drug Dependency

☐ Other - Please specify ……

SPECIAL REQUIREMENTS (e.g. transport needs, literacy issues, learning disabilities):

Please specify in the box below

Please note: This service is **not** suitable for those with severe learning disabilities. However, limited guidance can be given to carers, please ring prior to referring.

MENTAL HEALTH AND WELLBEING

Is patient currently under the care of a psychiatrist or mental health team/service?	Yes ☐ No ☐

If yes, please provide details below. Please include with this form any recent reports from these services.

……

Psychological or Psychiatric Conditions

Please tick all that apply and state whether they are historic or current

Please include PHQ or GAD scores if completed.

	Historic	Current
Anxiety	☐	☐
Depression	☐	☐
Psychosis	☐	☐
Bipolar Disorder	☐	☐
Eating Disorder	☐	☐
Self harm	☐	☐
Suicide Attempts	☐	☐
Personality Disorder	☐	☐
Other (please specify)	☐	☐

……

If you have any additional information on these conditions, please specify here or include with this referral form

Risk issues for staff (e.g. Inappropriate behaviour, violence or aggression):

Risk issues for patient:

MEDICATION : ***Please attach a printout of all current medications***

CLINICAL INVESTIGATIONS *Please record results for all the investigations listed below. This form cannot be accepted unless all measurements and scores have been performed, and all have been performed within the past year (except 24hr urinary cortisol).* ***Alternatively, please enclose a printout of these investigations***

If diabetic: HbA1c	Result	Date
If not known diabetic: Fasting blood glucose	Result	Date
Thyroid function	Result	Date
24 hour urinary cortisol (*If suspected Cushing's only)*	Result	Date
Sleep apnoea Epworth score	Result	Date

SURGERY/PRACTICE-BASED WEIGHT MANAGEMENT HISTORY
Please specify any relevant information relating to weight management history including weight loss medication

CONSIDERATIONS BEFORE REFERRAL (Please read carefully)

If your patient has a history of poor attendance or poor compliance with medication/other treatment or is unable to give weight loss a high priority right now then he/she may find it difficult to engage with the SWMS programme and be at risk of being discharged. Please consider the referral carefully.

☐ **This patient is ready and able to engage in a weight management programme**

REFERRER'S SIGNATURE	Signature …… Print name ……	Date ……