REFERRAL TO DORSET TIER 3
SPECIALIST WEIGHT MANAGEMENT PROGRAMME

PLEASE NOTE: ALL REFERRAL WILL BE RETURNED IF ANY PARTS OF THE FORM ARE INCOMPLETE
(Referral must be complete in order to help The Weigh Ahead team devise a more appropriate and safe programme for patients)

1. PATIENT INFORMATION:

NHS Number:
Date of Birth:
Name:
Address:

Telephone Number:
Mobile Number:

Practice Health Advisor/other Health Care Professional:

Name: Contact Details:

2. GP INFORMATION:

GP Name
GP Address:

GP Telephone:
GP Fax:
Referral Date:

3. PATIENT MEDICAL HISTORY **(BMI MUST BE >40 OR >35 PLUS DIABETES AND/OR CO-MORBIDITIES)**

Height(m): ……

	At point of Request	3 months previously	6 months previously
Weight(kg)			
BMI			

Blood Pressure: …….

Past Medical History:

Hypertension YES ☐ NO ☐
Diabetes YES ☐ NO ☐
Severe arthritis YES ☐ NO ☐
Cardiac Condition YES ☐ NO ☐
Asthma/COPD YES ☐ NO ☐
Obstructive Sleep Apnoea YES ☐ NO ☐

Other Conditions:

THE FOLLOWING BLOOD TEST RESULTS FROM WITHIN PAST 6 MONTHS MUST BE ATTACHED TO REFERRAL

(Please indicate values below or attach additional sheet)

Lipid Profile _____ Thyroid Function _____ Fasting Blood Glucose ___ HbA1c (if diabetic)_____

Current Medication: - or attach additional sheet

Mobility:

Are you aware of any absolute contraindications why your patient CANNOT exercise as part of the specialist weight management service? (Please indicate) YES ☐ NO ☐

Any special needs or recommendations with regards to exercise component:

Weight Management History:

PATIENT MUST HAVE ENGAGED & COMPLIED WITH TIER 1 & 2 SERVICES FOR MINIMUM PERIOD OF 2 YEARS PRIOR TO REFERRAL

Please provide relevant details below including reasons where an intervention has not been accessed or is contraindicated:

Commercial Weight Management (e.g. Weight Watchers, Slimming World) YES ☐ NO ☐

Dates/weight lost…..

Dietary weight loss products (e.g. meal replacement shakes) YES ☐ NO ☐

Dates/weight lost……

GP/Practice Nurse support YES ☐ NO ☐

Dates/weight lost……

Dietitian / Diabetes Specialist Nurse support YES ☐ NO ☐

Dates/weight lost……

Exercise programmes/interventions YES ☐ NO ☐

Dates/weight lost……

Psychological Interventions/Cognitive Behaviour Therapy YES ☐ NO ☐

Dates/weight lost……

Anti-Obesity Medications YES ☐ NO ☐

Orlistat Other(Give details)

Dates/weight lost…

Dietary Information – please include allergies or conditions such as coeliac disease

Mental Health History please list any current /past history and severity, and any history of aggression/violence

Previous Bariatric assessment/surgery YES ☐ NO ☐

Dates/details…

Eating Disorder Screening Please ask the patient the following questions:

Never Sometimes Often

1. In the past month, have you eaten till you felt uncomfortably

full but felt that you could not stop? ☐ ☐ ☐

2. Do you eat normally in public but excessively in secret? ☐ ☐ ☐
3. Do you have a feasting and fasting pattern of eating? ☐ ☐ ☐
4. Do you ever make yourself sick or take laxatives to control your weight? ☐ ☐ ☐

Assessing readiness to change

Please ask the patient where they would rate themselves using the scale below:

1. How *important* do you feel it is for you to make a change to your lifestyle?

1 2 3 4 5 6 7 8 9 10

LOW ←----------→ HIGH

2. How *confident* do you feel that you can make a change to your lifestyle?

1 2 3 4 5 6 7 8 9 10

LOW ←----------→ HIGH

Do you feel the patient is fully prepared to commit to the 6 month weight management programme?

(Please indicate) YES ☐ NO ☐

Referrer Name: Referrer Designation:

Referrer Signature: Date:

Patient Declaration

I want to participate in the tier 3 weight management service and give permission for any relevant information to be sent to the service:

Patient Signature: Date

REFERRAL TO *'The Weigh Ahead'*
TIER 3 SPECIALIST WEIGHT MANAGEMENT PROGRAMME

Please note there are certain exclusion criteria for admittance into the service. If your patient falls into this criteria but you feel may benefit from some input, please contact us for further advice and guidance.

Exclusion Criteria:

- Any patient with serious uncontrolled disease, e.g. angina, asthma, COPD, heart failure
- Recent complicated myocardial infarction and/or awaiting further investigation
- Uncontrolled arrhythmia that compromises cardiac function
- Blood pressure at rest above 180mg systolic, 120mg diastolic.
- Patients with an unstable psychiatric disorder
- Acute infection

Please note that for pregnant patients support is available via our education and specialist advice service with a view to return to Tier 3 following medical post-natal clearance.

Contact details:

Telephone: 02380 764964 **Fax:** 02380 512757 **E-mail:** SPIRE.Tier3DorsetWMS@nhs.net