healthy weight

TIER 3 SPECIALIST WEIGHT MANAGEMENT SERVICES

Kent GP Referral Form For Professional Use Only

Referral Criteria

- Adults over 18 years old
- BMI ≥35 with related co-morbidities these being primarily diabetes and/or cardiovascular disease or
- BMI ≥40 without related co-morbidities
- BMI ≥32.5 Asian family origin with recent onset* type 2 diabetes mellitus
- Individuals who have complied with Tiers 1 and 2 services for at least six months and have failed to achieve or maintain weight loss goals.
- Post two years bariatric patients who require specific post-operative support.

NB: We cannot accept patients who have experienced suicidal ideation or have self-harmed in the past 6 months. Any patient experiencing unstable/erratic mental health issues will be referred to their GP for appropriate medical care.

PATIENT DETAILS	
Name	Sex
Address	
Date of Birth	NHS Number
Telephone Home	Telephone Work

MEASUREMENTS Attach graph of weight if available			
Date of measurements:	Weight (kg):	Height (cm):	BMI:

BASELINE MEDICAL STATUS AND HISTORY		
SELECT IF APPLICABLE		DATE OF DIAGNOSIS AND BRIEF DETAILS
Hypertension		
Diabetes		
Coronary heart disease (angina, MI)		
Stroke or TIA		
Other relevant conditions		
Previously been referred for bariatric surgery (Tier 4)		☐ Yes ☐ No
Previously attended Tier 2 weight management support (community based groups)		☐ Yes ☐ No

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CURRENT MEDICATION

BASELINE BLOOD TESTS (LAST 3 MONTHS)

TYPE	DATE & RESULT	TYPE	DATE & RESULT
Thyroid function		Cholesterol (total)	
HBA1C		Triglycerides	
Other relevant tests			

This MDT programme involves the patient undergoing Psychology, Dietetics and Exercise components. Please indicate any details that you feel it would be useful for the service provider to be aware of.

This patient is able to engage in regular structured physical activity, which will be delivered by an appropriately trained fitness instructor. This will include cardiovascular exercise.

Please tick: ☐ Yes ☐ No

If not why not:

REFERRING GP/CONSULTANT/HEALTH PROFESSIONAL

Name	Signature	Date

GP PRACTICE NAME AND ADDRESS

Please send this form electronically to bariatric.consultancy@nhs.net Fax: 01322 220307