MORELIFE ADULT

REFERRAL FORM ESSEX

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| **Patient Details** |
| Title: |  | Date of birth: |  |
| First name: |  | Gender: | [ ]  Male [ ]  Female |
| Surname: |  | Patient preferred contact number: |  |
| Patient Address  |  |  |  |
| Postcode: |  | Does the patient speak English? | [ ]  Yes [ ]  No |
| NHS Number: |  | Does the patient have a longstanding limited illness or disability? | [ ]  Yes [ ]  No |
| If yes, please state: |  |
| **Email address** (this will be the main method for contacting the patient): |  |  |
| Does the patient have any mobility issues or are they housebound?  | [ ]  Yes [ ]  No |  |
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| **Current Medical Information** |
| Height (m): |  | Weight (kg): |  | BMI: |  |
| Blood Pressure: |  | Resting Heart Rate: |  |  |  |
| Does the patient meet the EoE clinical criteria for Bariatric Surgery? (BMI>40kg/m2 PLUS severe sleep apnoea and/or Type 2 Diabetes) | [ ]  Yes[ ]  No |

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| **Referral Criteria For Essex** | Referrer  |
| **One of the following three criteria MUST be met** | **Confirm** |
| A BMI of 40 kg/m2 or more | [ ]  **OR** |
| A BMI of ≥ 35 kg/m2 and 1 obesity-related comorbidity e.g. Type 2 Diabetes, metabolic syndrome, hypertension, obstructive sleep apnoea (OSA), functional disability, infertility and depression if specialist advice is needed regarding overall patient management | [ ]  **OR** |
| A BMI of ≥ 32.5 kg/m2, type 2 diabetes and of Asian descent | [ ]  **OR** |
| In exceptional circumstances when a patient with a BMI < 35 kg/m2 is referred, waist circumference and reasons for referral should be given as prior approval is required from the CCG  | [ ]  |

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| Use this area to supply further information evidencing how the patient meets the above criteria if necessary: |
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| **Pathology** *(Where available please ensure these are from the last three months)* |
| Hb1AC | Date: | Reading:  | TSH | Date:  | Reading:  |

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| **Medical History and Current Medication** |
| Medical History | Attached | [ ]  | Current Medication | Attached | [ ]  |

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| **Referral Source details** |
| Patient’s Surgery Name: |   |
| Surgery Address:  |
| Surgery Postcode: | Surgery contact number: |
| Referrer’s name: |  | Referrer’s profession: |  |
| Referrer’s Email: |  | Date of referral: |  |

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| **Exclusion Criteria\***Please NOTE – patients referred who suffer from the following conditions will be excluded: |
| Active Bulimia |
| Currently Pregnant |
| Active Psychosis |
| Active Substance Use Disorder (SUD) including Alcohol |
| Dementia |
| Had Bariatric Surgery in the last 12 months |
| \* Patients found to have a score of severe anxiety/depression will be assessed on an individual basis |

Please email to morelife@nhs.net or fax to 0844 209 0884 with any supplementary patient pathology records which need to accompany the referral form.

You can also return via post to: MoreLife (UK) Ltd, Thames Enterprise Centre Building, Thames Industrial Park, East Tilbury, RM18 8RH