MORELIFE TIER 3 ADULT WEIGHT MANAGEMENT

REFERRAL FORM-GREATER MANCHESTER

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| **Patient Details** | | | | | | |
| Title: | |  | Date of birth: | | | |
| First name: | |  | Gender: |  | | |
| Surname: | |  | Patient preferred contact number: | | | |
| Patient Address |  | | | | | |
| Postcode: | | | Does the patient speak English? | | |  |
| NHS Number: | |  | Ethnicity: | | | |
| **Email address**: | | |  | |  | |
| Is the patient housebound? | | |  | |  | |
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| **Current Medical Information** | | | | | |
| Height (m): |  | Weight (kg): |  | BMI: |  |
| Blood Pressure: |  | Resting Heart Rate: |  | | |

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| **Referral Criteria for this service** | **Referrer**  **Confirm** |
| **One of the following three criteria MUST be met – ALL CCG’S WITH THE EXCEPTION OF BURY\*** |
| Adults with BMI > 50kg/m2 who are being considered for bariatric surgery | **OR** |
| Adults with BMI 35kg/m2 and above | **OR** |
| Adults with eating disorders associated with their obesity (BMI 35kg/m2 and above). | **OR** |
| Pregnant women with BMI 35kg/m2 and above. |  |
| Adults from Black and Minority Ethnic (BAME) communities with BMI 35 kg/m2 |  |
| \*FOR BURY Adults on the Bariatric pathway with BMI 40kg/m2 and above. |  |

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| **Medical conditions** | | | | | |
| CDV, heart disease, previous heart attack or angina |  | Stroke or mini Stroke |  | Kidney Disease |  |
| Diabetes Type 2 – (non-insulin dependents) |  | Diabetes - Type 2- (insulin dependent) |  | Diabetes (Type 1 - insulin  dependent) |  |
| High BP - not medicated |  | High BP – medicated |  | Cancer or treated for cancer in the last 5 years |  |
| Depression or Anxiety |  | Other mental health  condition |  | MS or MND |  |
| Inflammatory conditions i.e. rheumatoid arthritis |  | Musculoskeletal pain i.e. osteoarthritis, back pain |  | Osteoporosis |  |
| Fibromyalgia |  | Respiratory disease, including asthma and chronic  pulmonary disease |  | Sleep apnoea |  |
| Fatty liver |  | Hypothyroidism |  | Other |  |
| If other please detail: | | | | |  |

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| **Medical History (relevant to this referral)** |

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| **Current Medication** |

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| **Biomedical readings (dated within the last three months):** | | | |
| **FULL lipid profile please** | | | |
| **Cholesterol** |  | **Date:** |  |
| **HDL** |  | **Date:** |  |
| **LDL** |  | **Date:** |  |
| **Triglycerides** |  | **Date:** |  |
| **HBA1C** |  | | |
| **Fasting Glucose** |  | | |
| **eGFR** |  | | |
| **TFTs** (a normal result from within the last 24months is accepted) | | | |
| **T4:** |  | | |
| **TSH:** |  | | |

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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: |
| Uncontrolled alcohol or drug dependency. |
| Poorly controlled major mental health illness, such as psychosis, severe depression, bulimia nervosa. |
| Newly diagnosed or uncontrolled hypothyroidism. |
| Chronic kidney disease stage 4+ requiring specialist renal advice. |
| Decompensated liver disease requiring specialist hepatic advice. |
| \* Patients found to have a score of severe anxiety/depression will be assessed on an individual basis |

Please email to [morelife.GM.SAWM@nhs.net](mailto:morelife.GM.SAWM@nhs.net) with any supplementary patient pathology records which need to accompany the referral form.

If you have any questions, please feel free to call us on 0161 511 0300