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| **CHECKLIST. PLEASE TICK ALL THREE BOXES BELOW WHEN COMPLETE.**  **WFB referrals cannot be accepted for triage without the following:** | | | | | | | |
|  | | | Patient Medical Summary is attached to this referral | | | | |
|  | | | BMI has been selected on the referral form | | | | |
|  | | | History of unsuccessful Weight Loss / maintenance at Tier 2 | | | | |
|  | | |  | | | | |
| **Referral Criteria** | | | | | | | |
|  | |  | BMI ≥40 (BMI ≥37.5 for Black, Asian and other minority ethnic groups) **OR** | | | | |
|  | |  | BMI ≥30 with related co-morbidities (BMI ≥27.5 for Black, Asian and other minority ethnic groups) | | | | |
| **Related comorbidities** | |  | Click or tap here to enter text. | | | | |
|  | |  |  | | | | |
| **Previous attempted weight management at Tier 2 (please select all relevant):** | | | | | | | |
|  | Slimming World / Weight Watchers inc. duration of attendance | | | Click or tap here to enter text. | |  | Dietitian |
|  | NHS Digital Weight Management Programme inc. duration of attendance | | | Click or tap here to enter text. | |  | Weight reducing medication |
|  | Other weight loss programme **(please state)** : Click or tap here to enter text. | | | | | | |
| **BOTH below should apply. Please tick to confirm:** | | | | | | | |
|  | Adult (over 18) who is motivated to undertake lifestyle change | | | | | | |
|  | Ability and commitment to 90% attendance throughout the group programme | | | | | | |
| **Exclusions** | | | | | **Only refer once stable** | | |
| * Pregnancy or breastfeeding * Uncontrolled hypertension/ heart condition/ medical condition preventing increase in activity-level * People who have attended or completed a tier 3 course before; unless something significant has changed, which is to be discussed on individual basis with course clinicians and specialist GP * Previous Bariatric Surgery (unless gastric band removed or not filled) * Eating disorder more appropriately treated by specialist services * Significant concern about risk to self or to others | | | | | * Alcohol or drug abuse * Psychiatric illness * Hypothyroidism * Cushing’s syndrome | | |
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| **Patient Information** | | | |
| **Name:** | | **Date of birth:** | **Gender:** |
| Click or tap here to enter text. | | Click or tap here to enter text. | Choose an item. |
| **NHS Number:**  Click or tap here to enter text. | | | **Ethnicity:** |
| Click or tap here to enter text. |
| **Address:** | | **E-mail Address:** | **Consent to receive WFB email:**  Choose an item. |
| Click or tap here to enter text. | | Click or tap here to enter text. |
| **Telephone (Mobile):** | Click or tap here to enter text. | | **Consent to leave message?** |
| **Telephone (Home):** | Click or tap here to enter text. | | Choose an item. |

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| **Medical Information** | | | | | | | | | |
| Current (date measured): | | | | Click or tap to enter a date. | | | | | |
| Weight (kg): | |  | | | Height (cm): | |  | **BMI:** |  |
| Waist circumference: | | |  | | Blood pressure: | |  | HbA1c |  |
| Chol: |  | | | | Triglycerides: | |  | LDL: |  |
| HDL: |  | | | | ALT: |  | | TSH: |  |
| The programme involves making lifestyle changes, and includes dietetic, exercise and psychology components. **Please note any other patient details** relevant to the referral, including those that may prevent the patient being able to engage fully in the programme below.  *NB: A physiotherapy assessment does not come as part of the programme, and by signing this referral form you agree that the patient is not at increased medical risk from carrying out self-managed graded activity/exercise. Please also discuss this with your patient.* | | | | | | | | | |
| **Additional Information:** | | | | | | | | | |
| Click or tap here to enter text. | | | | | | | | | |
| *NB: A physiotherapy assessment does not come as part of the programme, and by signing this referral form you agree that the patient is not at increased medical risk from carrying out self-managed graded activity/exercise. Please also discuss this with your patient.* | | | | | | | | | |

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| **GP name:** | Click or tap here to enter text. |
| **GP practice:** | Click or tap here to enter text. |
| **GP practice secure email:** | Click or tap here to enter text. |
|  |  |
| **Referred by (Name**): | Click or tap here to enter text. |
| **Profession:** | Click or tap here to enter text. |
| **Signed:** |  |
| **Date:** | Click or tap to enter a date. |

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| **Please email this form ensuring a medical summary (including BMI)**  **is attached to Healthy Minds at**  [**healthy.minds@oxfordhealth.nhs.uk**](mailto:healthy.minds@oxfordhealth.nhs.uk)  **Without a medical summary we will be unable to accept**  **this referral for triage**  **For further information please call Healthy Minds on 01865 901600** |
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