TRAFFORD SPECIALIST WEIGHT MANAGEMENT SERVICE REFERRAL FORM

Please complete all sections - missing information will result in the referral being delayed

Email complete forms to MTLCOSPOSA@mft.nhs.uk

REFERRAL CRITERIA:

EXCLUSION CRITERIA:

REFER ONCE STABLE:

READINESS TO CHANGE ASSESSMENT: Tick box to confirm

Patient agrees referral to the Specialist Weight Management Service and understand that they must demonstrate a long-term commitment to making lifestyle changes.

PATIENT DETAILS:

Surname: Surname	**Name:** Given Name
Home Full Address (stacked)	**DoB:** Date of Birth
	NHS Number: NHS Number
Telephone: Patient Mobile Telephone / Patient Home Telephone	**Ethnic Origin:** Ethnic Origin
Next of Kin: Name: Contact details: NOK relationship to patient:	**Gender:** With which gender does patient identify – Female, including transgender women Male, including transgender men Non-binary Patient prefers not to say
GP: Usual GP Full Name	**GP Address:** Organisation Full Address (single line)

Client completed the Interim and returning for the Bariatric Education Course

MEDICAL INFORMATIOIN:

Weight	**Height**	**BMI**

Relevant biochemistry, for example - Blood Pressure HbA1c Single Code Entry: Serum cholesterol level... Single Code Entry: Serum high density lipoprotein cholesterol level... Single Code Entry: Serum low density lipoprotein cholesterol level... Single Code Entry: Serum triglycerides level... ALT Single Code Entry: Serum TSH (thyroid stimulating hormone) level...
Medication
Relevant medical history and diagnoses, including mental health – Problems Consultations

ACCESS NEEDS **COMMUNICATION NEEDS**

Is the patient housebound and needing home visits? Yes/No Any relevant information for home visit - animals of concern, gaining access etc	Communication needs due to disability or sensory loss? Yes/No If yes, please state… Interpreter required? Yes/No If yes, which language…
Any concerns about verbal or physical abuse from patient or relatives Yes/No If yes, please give details…	

PLEASE NOTE: A physiotherapy assessment is not part of the programme for every patient, 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.

REFERRER DETAILS:

Name:	Telephone number:
Designation:	Base:
DATE:	Short date letter merged

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