Weight Management Referral- Required Dataset for Referral

Essential Dataset: (without this information we cannot process the referral).

Patient Details

Name: _____

NHS No: _____

Address: _____

_____

_____

Postcode: _____ D.O.B. _____

Telephone:(hm)_____ /(mobile)_____

Can we contact the patient by telephone **Y / N**

Please indicate in the box below if the patient has any cultural/communication barriers that we need to be aware of. *Details of communication issues/needs (eg: interpretation requirements, hearing loss).*

Referrer's Details

Name: _____

Profession: _____

Surgery / Department: _____

GP name/Practice (if not referrer):

_____

Postcode / Box No: _____

Telephone: _____

E-mail: _____

Date of Referral: _____

Defined Co-morbidities: please tick if any present to your knowledge:

Type 2 Diabetes (HbA1c=>48)	☐	Previous gestational diabetes	☐
Severe osteoarthritis eg: requiring listing for joint replacement or in severe pain uncontrollable with analgesics	☐	Sleep apnoea	☐

Clinical Metrics (Recorded within 6 months unless indicated with an asterisk*)

Height* *(measured not self-report):* _____m Weight: _____ kg BMI: _____

Smoking Status: current / ex-smoker/ never smoked

Blood pressure: Diastolic: _____ Systolic: _____

Lipids (non fasting): Total _____ mmol/L HDL _____ mmol/L Total-C : HDL-C ratio _____

Contraindications to exercise: please tick if any present to your knowledge:

Medical professional has advised the patient not to exercise	☐	Uncontrolled Asthma	☐
Unstable angina	☐	Vertigo	☐
Uncontrolled atrial or ventricular arrhythmias	☐	Aneurysm	☐
Has **not** completed a supervised rehab programme following MI or cardiac surgery.	☐	Unstable or acute heart failure	☐

Any other relevant information: (including past cardiac conditions, communication issues, known eating disorders)

The following information would be useful:

Gender (drop down options) _____ Ethnicity(drop down options) _____

Family history of CHD: (male <55yrs, female <65yrs) YES/NO

Physical activity level via GPPAQ (if known) (drop down options)_____

Is the patient pregnant? Y/N Patient's email address: _____

Please email/send this form to the Healthy Lifestyles HUB administered by Health Promotion Devon: ***E-Mail:*** *ndht.hpd@nhs.net*
Post*: Culm Valley Integrated Centre for Health, Willand Road, Cullompton, EX15 1FE,* ***Tel:*** *01884 836024*

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