**South East London Tier 3 Healthy Living Programme**

**Referral Form**

This is a 12-month structured programme of **group** based sessions with a clinical MDT to support the complex needs associated with severe obesity. This programme is for patients who are (1) motivated to change their lifestyle and (2) able to commit to regular attendance at fortnightly group sessions held either virtually or face to face.

**If your patient has a BMI over 50kg/m2, you may wish to consider a referral to a Tier 4 weight management service in addition to the SEL Tier 3 Healthy Weight Programme. Tier 4 weight management services are for patients wanting to access complex obesity support. This includes full MDT assessment, pharmacotherapy (if eligible), genetic testing (if appropriate), and weight loss surgery.**

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| **Inclusion criteria:**   * Registered with a GP in Lambeth, Southwark, Lewisham, Bromley, Bexley * Aged 18 or over * **Motivated to change lifestyle behaviours**  |  |  |  | | --- | --- | --- | | **Eligibility Criteria** | | | | **BMI (kg/m2)** | | **Comorbidities** | | **White ethnicities** | **All other ethnicities** | | **≥ 30** | **≥ 27.5** | Patient was diagnosed with T2DM within last 2 years | | **≥ 35** | **≥ 32.5** | Patient has T2DM or 2 or more obesity comorbidities | | **≥ 40** | **≥ 37.5** | No obesity comorbidities required | | ***Obesity comorbidities are:***   * Hypertension * Idiopathic Intracranial Hypertension * NAFLD, NASH or other hepatic steatosis * Obstructive Sleep Apnoea or Obesity Hypoventilation Syndrome * Prediabetes * Previous stroke or myocardial infarction | | | | **Exclusion criteria:**   * Pregnant or planning pregnancy * Those receiving palliative or end of life care * Myocardial infarction or stroke within the last 3 months * For patient safety, blood pressure readings of >180 mmHg systolic OR >120 mmHg diastolic (consider re-referral when blood pressure is optimised) |

**Your referral will be rejected if information in shaded boxes is not completed or attached.**

* **COMPLETE ALL SECTIONS and SEND VIA e-RS**

If you are unable to access e-RS then please complete all **mandatory fields** manually or attach an existing letter that contains **all** required information.

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| **Screening Criteria** | |
| **Date of Birth:** |  |
| **Ethnicity:** |  |
| **Height:** |  |
| **Weight:** |  |
| **BMI:** |  |
| **Blood Pressure:**  *(within last 6 months)* | Systolic:  Diastolic: |
| **Diabetes Status:** | Prediabetes  T2DM (Date of diagnosis: )  No diabetes diagnosis |
| **Obesity comorbidities present:** | Hypertension  Idiopathic Intracranial Hypertension  NAFLD, NASH or other hepatic steatosis  Obstructive Sleep Apnoea or Obesity Hypoventilation Syndrome  Previous stroke or MI  None of the above |
| **Is the patient pregnant?** | Yes  No |
| **Has this patient had a recent diagnosis of cancer, or is currently receiving active cancer treatment?** | Yes  No |

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| **Patient Details** | | | |
| **Salutation:** | Mr  Mrs  Miss  Other (Specify: ) | | |
| **Name:** |  | | |
| **Address:** |  | Postcode: |  |
| **Telephone number:** |  | | |
| **Email address:** |  | | |
| **NHS number:** |  | | |
| **Gender:** | Male  Female  Other (Specify: ) | | |
| **GP Surgery:** |  | | |
| **GP Address:** |  | Postcode: |  |
|  | | | |
| **Referrer Details** | | | |
| **Name:** |  | | |
| **Occupation:** |  | | |
| **Address (if not GP):** |  | | |
| **Email address:** |  | | |
| **Telephone number:** |  | | |
| **Date of referral:** |  | | |
|  |  | | |
| **Full Medical History**  Please attach full medical history including allergies and full drugs list | | | |
| **Medicines currently used:** | | | |
| ***Please indicate other relevant comorbidities that are present:*** | | | |
| |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | | **Blood Tests Results**  Blood test results are required to assess patient safety for very low-calorie diets and eligibility for obesity pharmacotherapy. Referrals will be rejected if mandatory tests results are not present. | | | | | | | | | **Renal Function Test**  *(within last 12 months)* | **HbA1c**  *(within last 12 months)* | | | **Thyroid Function Test** | **Liver Function Test (incl. AST)** | **Lipids** | **Full Blood Count** | |  |  | | |  |  |  |  | |  | | | | | | | | | **Additional Requirements**  Select any additional support needs that your patient requires | | | | | | | | | **Language** | |  | Details: | | | | | | **Unstable mental health** | |  | Details: | | | | | | **Learning disability or difficulty** | |  | Details: | | | | | | **House bound** | |  | Details: | | | | | | **Mobility issues e.g. wheelchair bound** | |  | Details: | | | | | | **Other** | |  | Details: | | | | | | **Is this patient suitable to attend the first appointment which is an online group education session?** | | | Yes  No  Please describe if no e.g. require interpreter, significant learning disability or difficulty etc.; | | | | | | **Is this patient safe to exercise at low to moderate intensity?** | | | Yes  No | | | | | | **Are there any safety OR security issues involved in seeing this patient?** | |  | Yes  No  Please describe if yes; | | | | | | | | |

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| **Referrer and patient consent** |
| The referral has been discussed with the patient - they are willing to engage with a 12-month weight management programme and give their consent for this referral.  Please tick to confirm the above |

**All referrals must be sent via e-RS -** This service is cross mapped to several specialties, but all patients get seen by the Tier 3 service.  To find us on e-RS, select one of the following:

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| **Specialty** | **Clinic type** | **Service name** |
| Dietetics | Weight Management | SEL Tier 3 Healthy Weight Programme |
| Health Promotion | Weight Management | SEL Tier 3 Healthy Weight Programme |

**If you are unable to access e-RS then please email this completed form to:**

[**gst-tr.tier3@nhs.net**](mailto:gst-tr.tier3@nhs.net)