**Lambeth Tier 2 Adult Weight Management Referral form**

**By referring this patient to the Tier 2 Weight Management Service you are providing consent that the patient is safe to exercise at moderate intensity.**

**If this patient is NOT safe to exercise at moderate intensity, please tick this**

**box** ☐

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| **Referral criteria** | |
| The referral criteria for this service is:   * Adults (aged 18 or over) with a BMI of between 30-35kg/m2 and who have one or more obesity related co-morbidity * BAME adults (aged 18 or over) with a BMI of 27.5kg/m2 and who have one or more obesity related co-morbidity * Adults (aged 18 or over) with a BMI of between 35 - 39.9kg/m2 | If your patient meets the referral criteria please tick the box |

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| **Demographic Details** | |
| Client Name:  Address:  Postcode:  Landline number:  Mobile number:  Can a voicemail be left? Yes / No  Date of Birth: Gender: M / F | NHS number:  GP Name:  GP Surgery: |
| Referred by: As above  Occupation:  Service name and address:  Telephone number: |

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| **Ethnicity (please tick as appropriate)** | | | | | | | | | |
| **White** | | **Mixed** | | **Asian or Asian British** | | **Black or Black British** | | **Other Ethnic Groups** | |
| British |  | White and Black Caribbean |  | Indian |  | Caribbean |  | Chinese |  |
| Irish |  | White and black African |  | Pakistani |  | African |  | Any other ethnic group please state: |  |
| Any other white background |  | White and Asian |  | Bangladeshi |  | Any other black background |  | Not Stated |  |
|  |  | Any other mixed background |  | Any other Asian Background |  |  |  |  |  |

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| **Client Status as at (dd/mm/yy) ….../….../..….** | | | | |
| **Blood Pressure** | **Height** | **Weight** | **BMI** | **Smoker?**  **Yes/No** |

Has the client completed an NHS Health Check? **Yes/No** CVD Risk Score…………%

***For GP and Practice Nurse only:******Please insert full medical extract here,: N.B. referrals without a medical extract will be returned.***

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| **Relevant Medical History** | **Current Medication** |
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| **Reason for referral** |
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| **Referrals for exercise– these will not be accepted for clients who have been referred within the last**  **2 .** |
| 1. If the client has a long term condition, have they been stable for at least 6 months? Yes No  2. Clients with Diabetes – have they attended a Diabetes Education session recently? Yes No  3. Is the client able to walk independently (without human assistance)? Yes No  **If the answer to any of the above questions is ‘no’ the client is not likely to be suitable for exercise sessions and may be offered an alternative service.**  4. Is the client currently undergoing any medical investigations? Yes No  If so, please specify…………………………………………………………………………………………….  ……………………………………………………………………………………………………………………. |

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| **Referrer and client consent** |
| The information on this form is an accurate representation of the client’s health status. The referral has been discussed with the client who has given their consent.  Signed: Date: |

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| **Please send the completed referral form to** | |
| Lambeth Early Intervention and Prevention Service  Mary Sheridan Centre, 5 Dugard Way London, SE11 4TH | **Tel:** 020 3049 5242  **Email:** GST-TR.ReferralsLEIPS@nhs.net |