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why weight
TIER 3 SPECIALIST WEIGHT MANAGEMENT SERVICE

WORKING together
To deliver your NHS for our communities

Crawley Clinical Commissioning Group
Horsham and Mid Sussex Clinical Commissioning Group

Referral Form

Tier 3 Weight Management Service

REFERRAL CRITERIA –Adults (18 years and over)

- BMI ≥30 with recent onset Type 2 Diabetes
- BMI ≥35 with a related co-morbidity
- BMI ≥ 35 who have been unsuccessful at Tier 2 after 6 months
- BMI ≥40 without related co-morbidities
- Asian ethnicity **and recent diagnosis of diabetes** with a BMI over **27**
- Patients for assessment and preparation for Tier 4 Specialised Morbid Obesity service
- Post-bariatric surgery patients who require specific post-operative support – Patients must be post 2 years
- **NB: We cannot accept patients who have experienced suicidal ideation or have self-harmed in the past 6 months. Any patient experiencing unstable/erratic mental health issues will be referred to their GP for appropriate medical care.**

Patient Details:		**Referrer Details:**
Name:	Sex: M/F	Referrer:
		Contact:
Address:		GP & Practice Name:
D.O.B:	NHS number	Practice Address:
Contact tel (home):		
Contact tel (mobile):		Contact tel:

Weight (kg): **Height (cm):** **BMI:**

Date Measurements taken:

Baseline Medical Status and History		
Please x if applicable		**Date of diagnosis and result**
Hypertension		
Diabetes		
Coronary heart disease (angina, MI)		
Stroke or TIA		
Kidney Disease		

Is this patient being referred for bariatric surgery (Tier 4)	**Yes ☐**	**No ☐**
Previously attended Tier 2 weight management (community based groups)	**Yes ☐**	**No ☐**

Current Medication

SEND REFERRAL TO
Email: bariatric.consultancy@nhs.net /Fax: 01322 220307 Enquiries tel Why Weight on 01293 223098

Mental Health History:

Baseline Results (last 3 months)			
Type	*Date & result*	*Type*	*Date & result*
Blood pressure		Cholesterol (total)	
HBA1C		LDL	
Thyroid function		HDL	
		Triglycerides	

The MDT programme involves components of psychology, dietetics and exercise components. Please indicate any details that you feel it would be useful for the service provider to be aware of.

Is patient is able to engage in regular structured physical activity delivered by an appropriately trained fitness instructor (including cardiovascular exercise). **Yes** ☐ **No** ☐

Interpreter needed **Yes** ☐ **No** ☐

Signed: _____ Date: _____