

Adult Weight Management Programme Referral Form - 2013

Patient Surname:	NHI:	Note: We do not accept patients who are currently pregnant or lactating or younger than 18 y/o.
Given Names:	DOB:	
Address:	GP:	
Contact phone numbers:		

Reason for referral:

BMI: or Weight: & Height:

Type 2 diabetes treated with
☐ diet ☐ oral meds ☐ insulin

Year of diagnosis of type 2 diabetes _____ NB: Must be within past 5 years

What was the last HBA1c? _____ Date: _____

Please indicate if your patient also has any of the following illnesses:

- ☐ Obstructive Sleep Apnoea or Obesity Hypoventilation Syndrome
- ☐ Ischaemic Heart Disease
- ☐ Congestive Heart Failure
- ☐ Cerebral Vascular Event
- ☐ Hypertension
- ☐ Dyslipidaemia If so, what was the last fasting lipid profile?
 LDL: _____ HDL: _____ TG: _____
- ☐ Renal Insufficiency If so, what was the last serum creatinine? _____
- ☐ Liver Failure If so, what was the last serum? _____
 AST/ALT: _____ / _____ GGT: _____ Alk Phos: _____ Tot. Billi: _____
- ☐ PCOS
- ☐ Gout
- ☐ Osteoarthritis that significantly limits physical activity
- ☐ Depression
- ☐ Eating Disorder
 ☐ Binge ☐ Bulimia Other _____

Is your patient required to lose weight to undergo surgery? ☐ Yes ☐ No
 If yes, for what type of surgery? _____

Please comment on any other medical illness:

P.T.O

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Other comments:

Print Referrer/GP
Name & Practice Address

Signature

Date

☐

PLEASE CHECK THAT ALL PATIENT CONTACT INFORMATION
IS UP TO DATE AND CORRECT

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PATIENT IS SUITABLE FOR A GROUP ENVIRONMENT

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PATIENT IS AWARE AND AGREES WITH REFERRAL

Revised June 2013