**Obesity/Bariatric Service Referral Form**

Tier 3 Weight Management & Tier 4 Assessment for Bariatric Surgery

Contact: Service Co-Ordinators: Tel: 01582 497420

**Please post or email to** [**ldh-tr.obesityreferrals@nhs.net**](mailto:ldh-tr.obesityreferrals@nhs.net)

**with all relevant information as requested below**

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| **Patient Details:** | **GP Details:** |
| Name (& Title): | Name of Referring GP: |
| Address: | Practice Code: |
|  | Practice Address: |
|  |  |
| Date of Birth: |  |
| Age: |  |
| NHS Number: |  |
| Tel (Home) | Tel: |
| Tel (Work) | Email: |
| Tel (Mobile) | GP CCG: (must complete) |
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| **Additional Information/Patient Needs:** | Transport should be organised by patient |
| Vision: | Carer or Guardian: |
| Hearing: |  |
| Speech: | Interpreter Required: |
| Learning Disability: | Language spoken: |

Is this referral for Medical Management (Tier 3)?  Yes / No 

(***please seek prior funding approval before referring, if this is required by your CCG***)

Is this referral for assessment for bariatric surgery (Tier 4)?  Yes / No 

*(****patient must have recently completed a local Tier 3 programme)***

*– please attach end of therapy report from Tier 3 service OR CCG approval letter if approved to refer directly to Tier 4)*

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| **Current Commissioning Criteria must be demonstrated. Where a patient’s BMI is between 35 and 40 the patient must have one or more co-morbidities as specified by your individual clinical commissioning group** |
| ***Height: Current weight: Current BMI:***  ***Co-Morbidities****:* please mark all as appropriate  Type 2 Diabetes Hypertension Obstructive Sleep Apnoea  Osteoarthritis Cardiovascular Disease  Metabolic syndrome   * Hypercholesterolaemia   Please specify Recent HbA1c (if applicable): Smoking Status: Current Ex smoker |
| Has the patient’s morbid/severe obesity been present for a minimum of 5 years? Yes / No  Please give a 5 year weight/BMI timeline :  How many years (if more than 5) has the patient suffered with morbid/severe obesity?:  Please detail all previous weight loss interventions: |
| Does the patient have any psycho-social factors or a history of psychiatric illness or treatment ☐ Yes / No ☐  Does the patient have current diagnosis or history of an eating disorder? ☐ Yes / No ☐  If yes, please detail:  *(Please attach any relevant correspondence from mental health services where appropriate)* |

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| **Reason for referral:** |
| Please summarise the reason for this referral: |

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| **Patient consent must be confirmed for all referrals:** |
| Is the patient aware of the proposed treatment and have they consented to this referral? ☐ Yes / No ☐  Has the patient consented to their personal/clinical information being shared with relevant services? ☐ Yes / No ☐  *Please ensure the patient is aware of the access criteria and which service they are being referred to initially.*  *Please advise the patient that Tier 3 must be completed according to CCG specifications before Tier 4 can be commenced* |

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| Signature of Referring Clinician: Date of Referral: |

You can post this form, with all relevant information to::

Referrals Co-Ordinator

The Obesity Service

Luton & Dunstable Hospital

Lewsey Road

Luton

Beds. LU4 0DZ

OR via Email: [ldh-tr.obesityreferrals@nhs.net](mailto:ldh-tr.obesityreferrals@nhs.net)

We cannot accept referrals via choose and book/ESR due to the complex nature of commissioning and pathways.