MORELIFE TIER 3 ADULT WEIGHT MANAGEMENT

REFERRAL FORM-GREATER MANCHESTER

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| **Patient Details** | |
| Title: | Date of birth: |
| First name: | Birth Gender: |
| Surname: | Patient preferred contact number: |
| Patient Address: | |
| Postcode: | Email address: |
| NHS Number: | Ethnicity: |
| Does the patient have a learning disability? | Does the patient speak English? |
| Does the patient have additional support needs? | First language: |
| Is the patient housebound? |  |

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| **Current Medical Information** | | | | | |
| Height (m): |  | Weight (kg): |  | BMI: |  |
| Blood Pressure: |  | Resting Heart Rate: |  | | |

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| **Referral Criteria for this service** | **Referrer**  **Confirm** |
| **One of the following three criteria MUST be met – ALL CCG’S WITH THE EXCEPTION OF BURY\*** |
| Adults with BMI > 50kg/m2 who are being considered for bariatric surgery | **OR** |
| Adults with BMI 35kg/m2 and above | **OR** |
| Adults with eating disorders associated with their obesity (BMI 35kg/m2 and above). | **OR** |
| Pregnant women with BMI 35kg/m2 and above. **\*\* please provide EDD and relevant info in ‘other’ box\*\*** |  |
| Adults from Black and Minority Ethnic (BAME) communities with BMI 35 kg/m2 |  |
| **\*FOR BURY\*** Adults on the Bariatric pathway with BMI 40kg/m2 and above. |  |

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| **Medical conditions** | | | | | |
| Chronic Kidney Disease |  | Hypercholesterolemia |  | High Blood Pressure (medicated) |  |
| CVD; including atrial fibrillation, hypertension, stroke TIA and/or angina |  | Pre-diabetes |  | High Blood Pressure (not medicated) |  |
| CHD such as previous MI or angina |  | Cancer or treated for cancer in the last 5 years |  | Mental Health Condition |  |
| Diabetes (Type 1 Insulin-dependent) |  | Dementia |  | MS or MND |  |
| Diabetes (Type 2 non-Insulin dependent) |  | Depression / anxiety |  | MSK pain / inflammatory condition including arthritis and fibromyalgia |  |
| Diabetes (Type 2 Insulin dependent) |  | Epilepsy |  | Osteoporosis |  |
| Heart Failure |  | Respiratory disease, including asthma and chronic  pulmonary disease |  | Respiratory disease; including asthma and COPD |  |
| Fatty liver |  | Hypothyroidism |  | Sleep apnoea |  |
| If other please detail: | | | | |  |

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| **Saxenda** | **Y/N** |
| Does your patient wished to be considered for Saxenda? |  |
| **Referral criteria for Saxenda – \*\*Referrer PLEASE CONFIRM that all of the following three criteria are be met\*\*** |  |
| BMI of at least 35 kg/m2 |  |
| Non-diabetic hyperglycaemia:   * HbA1c **42 to 47 mmol** / mol (6.0 to 6.4%) or Fasting plasma glucose 5.5 to 6.9 mmol/l |  |
| High risk of cardiovascular disease. Based on risk factors such as Hypertension and dyslipidaemia   * Total cholesterol > 5 mmol/L * Systolic Blood Pressure > 140 mmHg * HDL-C < 1.0 mmol/L for men * HDL-C < 1.3 mmol/L for women |  |
| Does your patient meet the above criteria for Saxenda? |  |
| Do you have supporting bloods to confirm eligibility? |  |

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| **Medical History (relevant to this referral)** |

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| **Current Medication** |

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| **Biomedical readings (dated within the last three months):** | | | |
| **Full lipid profile please** | | | |
| **HbA1c** |  | **Date:** |  |
| **Fasting Glucose** |  | **Date:** |  |
| **TFTs** (a normal result from within the last 24months is accepted) | | **Date:** |  |
| **TSH** |  | **Date:** |  |
| **T4** |  |  |  |
| **Cholesterol** |  | | |
| **HDL** |  | | |
| **LDL** |  | | |
| **Triglycerides** |  | | |
| **eGFR** |  | | |

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| **Referral Source details** | | | | |
| Patient’s Surgery Name: | |  | | |
| Surgery Address: | | | | |
| Surgery Postcode: | | | Surgery contact number: | |
| Referrer’s name: |  | | Referrer’s profession: |  |
| Referrer’s Email: |  | | Date of referral: |  |

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| **Exclusion Criteria\***  Please NOTE – patients referred who suffer from the following conditions will be excluded: |
| Uncontrolled alcohol or drug dependency. |
| Poorly controlled major mental health illness, such as psychosis, severe depression, bulimia nervosa. |
| Newly diagnosed or uncontrolled hypothyroidism. |
| Chronic kidney disease stage 4+ requiring specialist renal advice. |
| Decompensated liver disease requiring specialist hepatic advice. |
| \* Patients found to have a score of severe anxiety/depression will be assessed on an individual basis |

Please email to [morelife.GM.SAWM@nhs.net](mailto:morelife.GM.SAWM@nhs.net) with any supplementary patient pathology records which need to accompany the referral form.

If you have any questions, please feel free to call us on 0161 511 0300