**Everyone Health Bracknell Forest**

**Adult Weight Management Referral Form**

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| **Patient Details**  |
| Mr | ☐ | Mrs | ☐ | Miss | ☐ | Ms | ☐ | Other | ☐ | Transgender | ☐ |
| First Name |   |   |   | Surname |   | DOB | ../../.. | Age |   |
| Gender |   | Surgery |   | Carer |   |
| Address |   | Postcode |   | Telephone Number |    |
| Email |   | NHS Number |   | Mobile Number |    |
| **Medical Conditions and Relevant Conditions** |
| Anxiety/ Depression |   | Asthma |   | Cardiovascular Disease |   | Disability |   | Pre-Diabetes |   | Osteoporosis |   |
| Chronic Fatigue Syndrome |   | Dyslipidemia |   | Epilepsy |   | Severe Mental Illness |   | Type 1 Diabetes |   | Musculoskeletal Disorders (MSD) |   |
| Fibromyalgia |   | Hypertension |   | Sleep Apnea |   | Learning Disability |   | Type 2 Diabetes |   | Metabolic Syndrome |   |
| Post Bariatric Surgery |   | Pre-Bariatric Surgery  |   | Other (please state) |   |  |   |  |   |   |   |
| **Relevant Medication and Other Considerations/Co-Pathologies** |
|   |
| **Measurements:** |
| Height: | BMI: |
| Weight: | Blood Pressure: |
| **Consent** |
| **Please confirm you have discussed this referral with the patient and they wish to engage in the Healthy Lifestyle Service** | ☐ |
| **I confirm that the patient has agreed to share his/her data with Everyone Health** | ☐ |
| Referrer's Name: | Referring Organisation: |
| Referrer's Job Title: | Date: |

**Service**: **Tier 2 Adult Weight Management**: (BMI > 30kg/m2 or 27kg/m2 with comorbidities, or high-risk group without, or people from BAME groups). **To be completed by the referring Health Professional (all Health Professionals can refer).** All patient data will be kept securely and in accordance with Data Protection and Caldicott guidelines

**Please send completed referral form via one of the methods below**

**Email:** eh.bracknellforest@nhs.net **or Telephone: 03330050095**