**Weigh Forward**

**Grampian Specialist Weight Management Service**

**Referral Form**

Please send completed referral forms back to -

Specialist Weight Management Service

Rosehill Annexe, ARI, AB25 2ZG

Email – nhsg.swms@nhs.net

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| Patient Details |
| Name: Click here to enter text. |  |
| DOB: Click here to enter text. | CHI: Click here to enter text. |
| Address: Click here to enter text. |  |
|  Click here to enter text. |  |
|  Click here to enter text. |  |
|  Click here to enter text.  | Gender: Choose an item. |
| Telephone: Click here to enter text. | Mobile: Click here to enter text. |
| Email address: Click here to enter text.  | Preferred method of contact: Choose an item. |

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| Referrer Details | GP Details |
| Name | Click here to enter text. | Name | Click here to enter text. |
| Role | Click here to enter text. | Practice | Click here to enter text. |
|  | Click here to enter text. |  | Click here to enter text. |
| Organisation | Click here to enter text. |  | Click here to enter text. |
|  | Click here to enter text. |  | Click here to enter text. |
| Telephone | Click here to enter text. | Telephone | Click here to enter text. |

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| Reason for referral  |
| Click here to enter text. |
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| Baseline Anthropometry |
| Weight: Enter Value | kg | Height: Enter Value | m | BMI: Enter Value | kg/m2 |

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| Related Co-morbidities |
| Dyslipidaemia: Choose an item. | Polycystic ovarian syndrome: Choose an item. |
| Metabolic syndrome: Choose an item. | Sleep apnoea: Choose an item. |
| Osteoarthritis: Choose an item. | Type 2 Diabetes: Choose an item. |
| Established cardiovascular disease: Choose an item. |
| Other (please specify): Click here to enter text. |

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| Clinical Results (if available) | Date |
| Total cholesterol Enter Value | mmol/l  | Click here to enter a date. |
| ALT Enter Value | U/l | Click here to enter a date. |
| Triglycerides Enter Value | Mmol/l | Click here to enter a date. |
| HbA1c Enter Value | mmol/mol | Click here to enter a date. |
| LDL Enter Value | mmol/l | Click here to enter a date. |
| HDL Enter Value | mmol/l | Click here to enter a date. |
| Blood pressure Enter Value  |  | Click here to enter a date. |

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| Recent medical/social history |
| Click here to enter text. |
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| Motivation to Change |
| Has patient engaged in a structured weight management service? Choose an item.(e.g. Healthy Helping/Commercial group)Name of service Click here to enter text. How long ago they attended Click here to enter text.On a scale of 1 to 10 how motivated is the patient to lose weight? (1 = not motivated 10 = very motivated) Choose an item.Is the patient able to attend outpatient appointments? Choose an item. |
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| Additional Information |
| Please provide any other relevant informationClick here to enter text. |

 Signed

 Name Click here to enter text.

 Date Click here to enter a date.