

This form contains confidential patient data - please ensure you follow the local policies for sending it securely

WEIGHT MANAGEMENT REFERRAL FORM

This referral form is for anyone in Central Bedfordshire looking for weight management support. Just complete this form and send it to us. Once we have received it, we will contact the patient to discuss which programme would suit them best.

You can type directly into this form or if this is a hard copy it's probably best to use a pen!

If you haven't got time to complete this form you (or someone from your organisation) can just give us a call 01234 363774 and pass on the details below over the phone.

Demographic Details:

Name..... NHS Number.....

Address

Full Postcode..... Date of Birth..... Gender (M/F)

Preferred Contact Number..... Parent/Guardian Name if child

Interpreter needed: Y / N If yes: which language:.....

GP Name:.....GP Address.....

Please list any co-morbidities:

Are there any safety / security issues involved in seeing this client: Y / N If yes, what?

.....

Pregnant: Y / N Due date.....

Ethnicity (insert appropriate letter from list below):

White	British Irish White other	A B C	Mixed	White/ Black Caribbean White / Black African White /Asian Mixed other	D E F G	Asian	Indian Pakistani Bangladeshi Asian other	H J K L
Black Or Black British	Caribbean African Black Other	M N P	Other Ethnic Groups	Chinese Any other ethnic group	R S	Not Stated	Not Stated	Z

	BMI	Tick Appropriate
Adult	BMI >27.5 kg/m ² of Black or minority ethnic (BME) origin and/or with comorbidities	<input type="checkbox"/>
Adult	BMI >30 – 39.9kg/m ²	<input type="checkbox"/>
Adult	BMI 40+ kg/m ²	<input type="checkbox"/>
Adult	If BMI 40+ This patient will be referred into additional support services. Prior to this do you (clinician) know of any risk with participation in a low intensity physical activity programme?... If Yes please explain:	<input type="checkbox"/>
Child	BMI 91st to 97.9th Centile	<input type="checkbox"/>
Child	BMI 98th+ Centile	<input type="checkbox"/>

PARQ Please complete the modified PAR-Q below	Y	N
Does this patient have a heart condition and should they only perform physical activity recommended by a doctor?	<input type="checkbox"/>	<input type="checkbox"/>
Does the patient feel any pain in their chest when performing physical activity?	<input type="checkbox"/>	<input type="checkbox"/>
In the past month, has this patient had chest pain when they were not performing physical activity?	<input type="checkbox"/>	<input type="checkbox"/>
Does the patient lose their balance because of dizziness or ever lose consciousness?	<input type="checkbox"/>	<input type="checkbox"/>
Does the patient have a bone or joint problem that could be made worse by a change in their physical activity level?	<input type="checkbox"/>	<input type="checkbox"/>
Is this patient currently being prescribed any medication for their blood pressure or for a heart condition?	<input type="checkbox"/>	<input type="checkbox"/>
Do you (clinician) know of any other reason why this patient should not engage in physical activity?	<input type="checkbox"/>	<input type="checkbox"/>
Does this patient have controlled or orally medicated diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, is there any reason this patient should not engage in a healthy eating programme?	<input type="checkbox"/>	<input type="checkbox"/>
Does the patient have uncontrolled diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
Do you (clinician) know of any reason why this patient should not take part in a healthy lifestyles programme which includes making healthy changes to their diet?	<input type="checkbox"/>	<input type="checkbox"/>

3. If you have answered yes to any of the questions in the PARQ, please state the limitations that should be imposed in delivering a healthy lifestyle intervention consisting of healthy eating and/or physical activity, Including whether they should not do any physical activity at all.

4. Are there any other issues or conditions that you need to make BeeZee Bodies aware of in order that this patient can safely engage in a healthy lifestyle programme consisting of healthy eating and/or physical activity?

5. Clinician Confirmation

I confirm this patient is suitable to attend a lifestyle programme consisting of physical activity and healthy eating advice. (unless otherwise advised in section 3+4)

6. Confirmation of Patients Wishes:

I refer this person to BeeZee Bodies to assist in finding the most appropriate weight management support and confirm I have sought the permission of the named person to send their details to BeeZee Bodies and that they wish to be contacted by a member of the BeeZee Bodies Team.

Clinician Name:

Date:

Sign/type: "I Agree".....

Please do NOT send this form by email

Please post this completed form to:

**Private & Confidential
BeeZee Bodies
23-27 Allhallows
Bedford
MK40 1LN**