**Please complete all sections of this form and check your local ICB’s BMI and eligibility criteria requirements before referring.**

Referrals can be sent by NHS Mail **OR** e-RS.

Fields marked **with a star \*** are **mandatory** - **referrals cannot be accepted without this data.**

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| **1. Patient Information** |
| **Patient Name\*:** |
| **Date of Birth\*:** |
| **Gender\*:** |
| **Ethnicity\*:** |
| **NHS Number\*:** |
| **Mobile number\*:** |
| **Alternative telephone number:** |
| **E-mail address:** |
| **Address including postcode:** |
| **Interpreter required (if yes, specify preferred language)**: |
| **Please document any reasonable adjustments required:** |

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| **2. Referrer information (GP Details)**  ***Referrals can only be accepted from a named GP*** |
| **Name of GP practice\*:** |
| **Practice Code\*:** |
| **Name of referring GP\*: Dr** |
| **Practice email (nhs.net email for clinical correspondence):** |

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| **3. Clinical information** | **Date (dd/mm/yyyy)** | **Value** |
| **Weight (in kg)\***  **MUST be within the last 12 months** |  |  |
| **Height (in cm)\*** |  |  |
| **BMI (kg/m2)\***  **MUST be within the last 12 months** |  |  |
| **HbA1c (mmol/mol)\***  **MUST be within the last 12 months** |  |  |
| **Blood pressure (mmHg)\*** |  |  |
| **Renal function (eGFR)\***  **MUST be within the last 12 months** |  |  |
| **Thyroid function (TSH)\***  **MUST be within the last 12 months** |  |  |
| **Total cholesterol\***  **MUST be within the last 12 months** |  |  |
| **HDL cholesterol\***  **MUST be within the last 12 months** |  |  |
| **LDL cholesterol\***  **MUST be within the last 12 months** |  |  |
| **Liver function (ALT)** |  |  |
| **QRISK2 Score (%)** |  |  |

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| **4. Retinopathy** |
| **Please confirm the following\*:**  Patient does not have Type 2 diabetes (no result needed)  Patient has Type 2 diabetes **and** retinopathy screening outcome result is attached\*  N/A Patient has new diabetes diagnosis  ***\*<Please attach a recent (<12 months) retinopathy screening outcome for patients who have Type 2 diabetes>*** |

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| **5. Exclusion Criteria** |
| **I confirm the patient does not meet any of the following exclusion criteria\*:**   * Pregnant or breastfeeding * Uncontrolled hypertension / heart condition / medical condition preventing increased activity level * Active or suspected eating disorders, including binge eating disorder * Bariatric surgery in the past two years * Unstable or severe mental illness, including suicide attempts in the past 12 months. This may prevent engagement with the behaviour change programme * Unstable alcohol or drug use (can be referred if the patient has received support and been in recovery for 3 months) * Unstable hypothyroidism (can be referred if stable) * Unstable Cushing’s syndrome (can be referred if stable) |

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| **6. Past relevant medical history/comorbidities** |
| NB: Without relevant medical history (particularly hypertension, dyslipidaemia and cardiovascular risk factor history), the patient may not be able to access GLP-1 therapy via the service.   * **if comorbidities are not covered in the above, please add them here**   ***\*<Insert medical history or attach patient summary> OR <Active problems and significant past>*** |

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| **7. Current medications** |
| ***\*<Insert current medication list or attach patient summary> OR <mix of repeat and acute medications>*** |

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| **8. Suitability for referral** |
| **Before completing the referral, please confirm the following\*:**  The patient has actively/persistently engaged with losing weight with a structured Tier 2 service or equivalent programme.  That the patient meets the BMI eligibility criteria for your local ICB - noting comorbidities and ethnicity.  That you have assessed the patient is ready or motivated to change and that they are fully committed to participating in the Oviva T3 programme.  That the patient is medically stable and that they do not require further investigation for an existing or new health condition. |

**Please send the completed referral form via secure NHS mail to** [ovivauk.t3wm@nhs.net](mailto:ovivauk.t3wm@nhs.net) **or submit it via e-RS.**