**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 **or submit it via e-RS.**