Adult Weight Management Programme Referral Form - 2015

Patient Surname:	NHI:
Given Names:	DOB:
Address:	GP:
Contact phone numbers:	

Note: We do not accept patients who are currently pregnant or lactating or younger than 18 y/o.

Reason for referral:

BMI: ____ **or Weight:** ____ **& Height:** ____

Prediabetes [] FPG ≥ 5.6 mmol or [] 2 hr GTT ≥ 7.8 mmol

Type 2 diabetes treated with
[] diet [] oral meds []insulin

Year of diagnosis of type 2 diabetes_____

What was the last HBA1c?_____ **Date:**_____

Please indicate if your patient also has any of the following illnesses:
[] Obstructive Sleep Apnoea or Obesity Hypoventilation Syndrome
[] Ischaemic Heart Disease
[] Congestive Heart Failure
[] Cerebral Vascular Event
[] Hypertension
[] Dyslipidaemia If so, what was the last fasting lipid profile?
LDL: _____ HDL: _____ TG: _____
[] Renal Insufficiency If so, what was the last serum creatinine? _____
[] Liver Disease _____ If so, what was the last serum?
AST/ALT: ____/____ GGT: _____ Alk Phos: _____ Tot. Bili: _____
[] PCOS
[] Gout
[] Osteoarthritis that significantly limits physical activity
[] Depression
[] Eating Disorder
[] Binge [] Bulimia Other _____

Is your patient required to lose weight to undergo surgery? []Yes [] No
If yes, for what type of surgery? _____

Please comment on any other medical illness:

P.T.O

Adult Weight Management Programme Referral Form

Other comments:

Print Referrer/GP
Name & Practice Address

Signature

Date

☐ **PLEASE CHECK THAT ALL PATIENT CONTACT INFORMATION IS UP TO DATE AND CORRECT**

☐ **PATIENT IS SUITABLE FOR A GROUP ENVIRONMENT**

☐ **PATIENT IS AWARE AND AGREES WITH REFERRAL**

☐ **PATIENT IS AWARE THAT OPTIFAST MEAL REPLACEMENT IS USED AND HAS A COST (~$70.00/wk in place of usual cost of food)**

Revised March 2015