**A picture containing graphical user interface

Description automatically generatedJanuary 2025**

# Complications of Excess Weight Service

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| Please send to CEW MDT Co-Ordinator at [plh-tr.cewservice@nhs.net](mailto:plh-tr.cewservice@nhs.net)  Based: CEW Team, Paediatrics Level 12, Derriford Hospital, Plymouth, PL6 8DH  Tel: 01752 437294  **All fields with \*\*\* are mandatory for this referral to be triaged by the CEW MDT.**  Date of referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Name, Profession, and contact details of referrer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| **Client details \*\*\*** | | | | |
| Full name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  NHS No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Sex: M  / F  Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Telephone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Parent / Carers details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  GP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  First language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Interpreter required: Y  / N | | | | |
| **Parental Consent \*\*\*** | | | | |
| Parental consent given for referral: Y  / N |  |  |  |  |
| **Weight/Height/BMI \*\*\*** |  |  |  |  |
| Weight: \_\_\_\_\_ Kg Date recorded:  Height: \_\_\_\_\_\_ cm Date recorded:  BMI: \_\_\_\_\_\_\_\_ Kg/m₂ Date recorded:    BMI SDS \_\_\_\_\_\_\_ Date recorded: | | | |  |
|  |
|  |
| **Complications of obesity \*\*\*** | | | | |
| Hypertension  Sleep Apnoea requiring intervention  Metabolic Liver disease  Diabetes T2  Polycystic ovarian syndrome  Idiopathic intracranial hypertension  Other (please state) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  None | | | | |
| **Social background \*\*\*** | | | | |
| Social worker: Y  / N  Name and contact details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Other professionals / agencies involved: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Risk / health and safety issues: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| **Possible underlying pathology** | | | | |
| *(EXAMPLE - Genetic cause / Living with learning or physical disability / Secondary cause of obesity suspected etc.)* | | | | |

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| **Motivation of CYP and family \*\*\*** | | |
| (EXAMPLE – Are they motivated for change? What have they previously tried? What are they currently doing?) | | |
| **Anything else relevant for this referral** | | |
|  | | |
| **Print** | **Sign** | **Date** |
|  |  |  |
| **Outcome – FOR CEW OFFICE USE ONLY** | | |
| **Date referral received:**  **/ /**  **Outcome:** | | |
| **Print** | **Sign** | **Date** |
|  |  |  |