**January 2025**

# Complications of Excess Weight Service

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| Please send to CEW MDT Co-Ordinator at plh-tr.cewservice@nhs.net Based: CEW Team, Paediatrics Level 12, Derriford Hospital, Plymouth, PL6 8DHTel: 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:  |  |
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| **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** |
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| **Print**  | **Sign**  | **Date** |
|  |  |  |
| **Outcome – FOR CEW OFFICE USE ONLY**  |
| **Date referral received:**  **/ /** **Outcome:** |
| **Print**  | **Sign**  | **Date** |
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