**A picture containing graphical user interface

Description automatically generatedApril 2022**

# Complications of Excess Weight Service

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| Please send to Samantha Stringer 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  Date of referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Name, Profession, and contact details of referrer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| **Client details** | | | | |
| Surname: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Forename(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date of birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: NHS No.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Telephone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Parent / Carers details: \_\_\_\_\_\_ GP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Parental consent given for referral: Y / N  First language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Interpreter required:  Social worker: Name and contact details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Other professionals / agencies involved: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Risk / health and safety issues: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| **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) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| **Possible underlying pathology** | | | | |
| *(EXAMPLE - Genetic cause / Living with learning or physical disability / Secondary cause of obesity suspected etc.)* | | | | |

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| **Anything else relevant for this referral** | | |
|  | | |
| **Print** | **Sign** | **Date** |
|  |  |  |
| **Outcome – FOR CEW OFFICE USE ONLY** | | |
| **Date referral received:**  **/ /**  **Outcome:** | | |
| **Print** | **Sign** | **Date** |
|  |  |  |