**NUH Complications of Excessive Weight (CEW) Clinic**

**Secondary Care Referral Form**

Please complete the following proforma or dictate a letter containing the appropriate information. Referrals are currently only being accepted from medical practitioners.

* Patients should be assessed for complications and, where identified, should be referred according to the usual pathways, with consideration of a dual referral to CEW, if appropriate. (For example, raised blood pressure use renal hypertension guideline).
* We understand that it may not be possible to undertake all suggested investigations in some patients and, where this is the case, it need not delay the referral. We operate a triaging system and waiting list. Identification of complications will help ensure patients are seen in the most appropriate order.
* Please ensure your patients are aware that there may be a long delay till they are offered an appointment and some patients may not be seen, and signpost to community resources.

Please email your completed referral to [cew.obesityem1@nhs.net](mailto:cew.obesityem1@nhs.net)

Paediatric Secretary for CEW: [anita.bennett7@nhs.net](mailto:anita.bennett7@nhs.net) 0115 9249924 ex: 83007

**Referral Criteria**

1. Age 1-17 with obesity as below:
2. BMI >4 SDS (12y+) OR BMI >5 SDS (1-11y) (even if no complications identified) + motivated (or part of Child Protection Plan)

**OR**

BMI SDS ≥ 2.67 SDS (99.6th centile) OR (≥2 SDS / 98th centile for BAME patients)1 for age and sex **and** one of the below

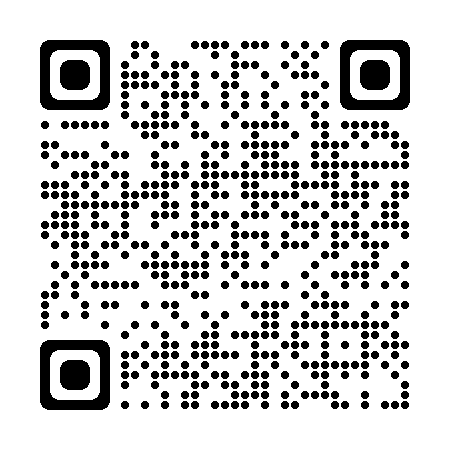
• One or more co-morbidities related to excess weight (NAFLD, pre diabetes (e.g. HbA1c 40-47 mmol/mol[[1]](#footnote-1)), OSA needing intervention, joint or mobility problems requiring surgery and/or causing severe impact on ADL, hypertension, Idiopathic intracranial hypertension, dyslipidemia, hidradenitis suppurativa, a significant psychological co-morbidity)

• Confirmed genetic cause of obesity

• Secondary cause of obesity such as pituitary surgery

• On a child protection plan for severe obesity

• Patient being considered for bariatric surgery

1. The Young Person and their parents/ carers have agreed to the referral and are motivated to engage with the service (unless they are on a child protection plan for severe obesity and engagement with the CEW service is a part of the plan. In these cases, please discuss with a CEW consultant prior to referring).

|  |  |  |
| --- | --- | --- |
| **Patient Demographics** | | |
| Name | |  |
| NHS Number | |  |
| DOB | |  |
| Address | |  |
| Phone Number | |  |
| Interpreter required Y/N  Y- specify language | |  |
| **Measurements** | | |
| Height/s (date/s)  (2-3 measurements if available helpful to identify trend) | | |  |  |  |  | | --- | --- | --- | --- | | Height |  |  |  | | Date |  |  |  | |
| Weight/s (date/s)  (2-3 measurements if available helpful to identify trend) | | |  |  |  |  | | --- | --- | --- | --- | | Weight |  |  |  | | Date |  |  |  | |
| BMI and SDS | | |  |  |  |  | | --- | --- | --- | --- | | BMI |  |  |  | | BMI SDS |  |  |  | | Date |  |  |  | |
| **Obesity-related co-morbidities**  *Please tick all that apply and provide details/attach results, where appropriate)* | | |
|  | Glucose dysregulation: | **If symptomatic, must do glucose meter testing and refer on same day if glucose ≥11.1mmol/l**   |  |  |  |  | | --- | --- | --- | --- | |  | Result (units) | Ref range | Date | | HbA1c: |  |  |  | | Fasting blood glucose: |  |  |  | | Random blood glucose: |  |  |  | |
|  | Obstructive Sleep Apnoea | *Please provide details of symptoms and investigations (if any):* |
|  | Non-alcoholic Fatty Liver Disease (NAFLD) | |  |  |  |  | | --- | --- | --- | --- | |  | Result (units) | Ref range | Date | | ALT: |  |  |  | | AST: |  |  |  | | US liver (if done): |  |  |  | | Other: |  |  |  | |
|  | Hypertension  If abnormal please repeat three measurements on separate days and, if remains high, refer/manage as per local guidelines.  ‘White coat’ hypertension very common  **Ensure correct sized cuff used** | |  |  |  |  | | --- | --- | --- | --- | |  | Date 1 | Date 2 | Date 3 | | Systolic: |  |  |  | | Diastolic: |  |  |  |   Manual or automatic:  Size of cuff used (if available)  Ambulatory BP: Yes/No – Report: |
|  | Dyslipidaemia (fasted if possible-Y/N) | |  |  |  | | --- | --- | --- | |  | Result | Date | | Triglycerides: |  |  | | Total cholesterol: |  |  | | HDL cholesterol: |  |  | | Other: |  |  |   Fasting? Y/N |
|  | Significant musculoskeletal problems | Please specify e.g. affecting activities of daily living, requiring previous surgery: |
|  | Idiopathic Intracranial Hypertension (IIH) | Please specify symptoms, investigations and medications (both previous and current): |
| **Learning/behavioural difficulties**  (including ADHD/Autism) | |  |
| **Current Medications** | |  |
| **Relevant Family and social history** | |  |
| **Safeguarding concerns (Y/N)**  If Y – please specify whether past or current, and provide name and contact details of social worker | |  |
| **Dietetic/weight management history**  Please specify what services and whether previous/current (with dates if available) | |  |
| **Mental health history**  Please include whether patient is known to CAMHS (and which service) and whether currently or previously | |  |
| **Any other relevant information** | |  |
| **Referrer details**  (Name, Speciality, Grade Trust) | |  |
| **Referral Date** | |  |

1. If symptoms of diabetes, check a point-of-care finger-prick glucose level and, if diabetes confirmed **refer same day to the local paediatric diabetes team**. If HbA1C or glucose level (POC or lab glucose) consistent with a diagnosis of diabetes, **refer same day to local paediatric diabetes team**. Children under-18 with any type of diabetes must be under secondary care [↑](#footnote-ref-1)