Nepean Family Metabolic Health Service

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ADULT HEALTHY WEIGHT MANAGEMENT CLINIC REFERRAL

Please note that there is a separate referral form for paediatric patients. If you are referring several members of one family, please indicate this on the referral. If you believe that your patient needs an urgent review, then contact the service by telephone directly.

In addition to this referral, please provide:

- ✓ ***an up-to-date medication list***
- ✓ ***a medical summary***
- ✓ ***any other relevant documents***

THIS IS AN INDEFINITE REFERRAL
(please delete if not applicable)

Please tick one of the boxes:

☐ **Dr Kathryn Williams** ***(or equivalent practitioner)*** ☐ **Adult Healthy Weight Clinic** ***(any doctor available on the day)***

Dear Doctor,

Thank you for seeing _____, Date of birth ___/___/___

of, _____ (address of the patient)

Contact phone number _____ in consultation for weight management.

Date of measure: _____ **Weight:** _____kg **Height:** _____ m

Calculated BMI: _____kg/m^2 **Waist Circumference:** _____ cm

Is the patient Aboriginal or Torres Strait Islander? **YES** ❑
Does the patient requires an interpreter? **YES** ❑ Language: _____
Can the patient read and write? **YES** ❑ **NO** ❑
Current smoker **YES** ❑ Quit smoking < 3 months ago? **YES** ❑

The patient is *willing and capable* of engaging with an obesity service and understands that this usually means *multiple appointments with many different providers, involving mostly group sessions*. They understand that there is *no guarantee of access to public bariatric surgery* given its limited availability: **YES** ❑ **NO** ❑

This patient may have problems attending groups and/or appointments due to: *(tick all that apply)*

Restriction to mobility ❑ **Details:** _____

Mental health problem ❑ **Details:** _____

Social circumstances/other ❑ **Details:** _____

Due to high demand, it is often not possible to accept referrals from outside the NBMLHD catchment area. Special consideration is made for patients requiring tertiary care and/or those needing services that are not provided by their local hospital or health service. Please contact us if you would like more information.

Name of Doctor: _____ Signature: _____

Practice Address _____

Practice Phone Number: _____ Practice Fax Number: _____ Date: ___/___/___

Please see next page for referral criteria for your completion.

Please ensure all relevant boxes have been ticked and evidence is provided with this referral. Failure to do so will delay acceptance of your patient onto the waitlist. Patients need to be well enough to attend multiple appointments.

Group A	BMI > 40 kg/m^2 and any of the following: → **Objective supporting evidence is required for items 2-6**	**1.** Age < 30 years	❑
		2. Type 2 diabetes • on multiple daily insulin injections (basal *and* bolus therapy) or • with HbA1c > 8.5% within the last 3 months or • age < 40 years	❑
		3. Non-alcoholic fatty liver disease with • NASH or liver fibrosis ≥ F2 on liver biopsy or • with FibroScan® measure > 10.3 kPa	❑
		4. Severe Obstructive Sleep Apnoea **(AHI > 30)** or Obesity Hypoventilation Syndrome/Sleep-Related Hypoventilation	❑
		5. Specific end-organ condition directly related to obesity, for example: • obesity-related cardiomyopathy (includes heart failure due to HFpEF) • benign/idiopathic intracranial hypertension • secondary focal segmental glomerulosclerosis	❑
		6. Assessed as appropriate for bariatric surgery by a surgeon actively participating in the public bariatric surgery program (by direct discussion between surgeon and Clinical Lead only) OR past history of bariatric surgery	❑
		7. Planning pregnancy within the next 24 months *and* aged < 40 years (females only)	❑
		8. Another family member being seen at NFMHS (please provide name)	❑
		9. Aboriginal or Torres Strait Islander background	❑
Group B	BMI > 55 kg/m^2 and any of the following: → **Objective supporting evidence is required for items 1-5 where possible**	**1.** Type 2 diabetes, pre-diabetes or history of GDM *and* age < 65 years	❑
		2. Severe or complicated hypertension *and* age < 65 years; includes: • BP not controlled on ≥ 3 agents or • evidence of end-organ effects from hypertension (e.g. LVH or albuminuria)	❑
		3. On waitlist for major surgery (cardiothoracic, abdominal, orthopaedic, neurosurgical) and required to lose weight to reduce operative risk	❑
		4. Recent frequent presentations to hospital (>2 within last 6 months) or prolonged admission (> 1 month) due to obesity related condition	❑
		5. PCOS with oligo/amenorrhoea (≤ 9 periods/year), DUB requiring gynaecological intervention or endometrial hyperplasia	❑
		6. Mobility < 20m due to shortness of breath or pain that is likely to improve with weight loss *and* age < 65 years	❑
		7. Age < 40 years	❑
Group C	BMI > 70 kg/m^2 and	Willing and able to attend visits at Nepean Hospital using own transport	❑
		May require home visits, Telehealth and/or phone coaching Reason:_____	❑
Group D	Age 16-18 years and	Meeting criteria for KidsFit4Future clinic	❑