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**Weight Management on Referral - One You South Gloucestershire**

**Patient Referral Form**

Please complete the relevant sections of this referral form for either an adult or family healthy weight referral:

* Refer to section **A, C and D** for an adult healthy weight referral (aged 18 years+).

***or***

* Refer to section **B, C and D** for a family referral to the *Healthy Weight Programme (families)* for families with children aged 5-17 years.

**Section A – (Adult Healthy Weight Referral)**

Patient details:

|  |  |  |
| --- | --- | --- |
| First Name: | | Last Name: |
| Address: | | |
| Postcode: | | Date of birth: |
| Telephone: | Consent for voicemail: ☐ (please tick) | |
| Email address:  *If the patient has access to email, then this is essential for the referral process.* | | |

Eligibility criteria:

1. Please tick to confirm that the patient meets the following criteria **☐**

* Aged 18 years or above.
* Has a BMI ≥ 30 (BMI ≥ 28 with co-morbidities or BMI ≥ 27.5 if Black-African, African-Caribbean, and Asian family origin).
* Patient is clinically stable.
* Patient is committed to complete a healthy weight intervention.
* Patient is not pregnant.
* Patient does not have a history of or an ongoing eating disorder.

1. Patient BMI (weight in kg/height in m2) *\*this must be a recent BMI within last 6 months\**

**BMI……………………**

If BMI is ≥ 27.5 is the patient:

Black African, African-Caribbean, South Asian or Chinese? Yes ☐ No ☐

If BMI is ≥ 28 does the patient have co-morbidities? Yes ☐ No ☐

If ‘Yes’ please state …………………………………………………………………………………………………

**\*\*\* Please note** – we are unable to accept referrals for patients with a BMI which is ≤ 30 unless they meet the above criteria. **\*\*\***

Equalities monitoring:

|  |
| --- |
| **Age:**  Under 1819-2425-4445-6465-74  Over 75  Prefer not to say |
| **Ethnic Origin:**  Arab  **Asian/Asian British**  Bangladeshi  Indian  Pakistani  Chinese  Other, please state……………………  **Black/African/Caribbean/Black British**  African  Caribbean  Other, please state………………………  Gypsy or Traveller of Irish Heritage  **Mixed/Multiple Ethnic Groups**  White and Asian  White and Black African  White and Black Caribbean  Other, please state………………………  **White**  English/Welsh/Scottish/Northern Irish/British  White – Irish  White – Other, please state………………….  Other ethnic group  **Other**  Other ethnic group, please state………………  Prefer not to say |
| **Gender:**  Female Male Other Prefer not to say |
| **Do you consider yourself to be disabled?**  No  Yes – Physical impairment, such as *difficulty using arms or mobility issues which may mean using a wheelchair or crutches.*  Yes – Sensory impairment, *such as being blind / having a serious visual impairment or being deaf / have a serious hearing impairment.*  Yes – Mental health condition, *such as depression, anxiety or schizophrenia.*  Yes – Learning disability/difficulty, *such as Down’s Syndrome, dyslexia, dyspraxia or cognitive impairment such as autistic spectrum disorder.*  Yes – Long standing illness or health condition, *such as cancer, HIV, diabetes, chronic heart disease or epilepsy.*  Yes – Other (please state) ………………………………………………………………………………  Prefer not to say.  If yes, please tell us how this affects the way that you access or use services…………………………………………………………………………………………………… |
| **Sexual Orientation**  Bisexual Gay man Gay woman/lesbian Heterosexual Other Prefer not to say |
| **Religion and/or Belief**  Buddhist Christian Hindu Jewish Muslim Sikh  No religion  Any other religion, please state…………. Prefer not to say |
| **Do you identify as a transgender person?**  Yes No Prefer not to say |
| **Which of the following describes your highest level of qualification?**  No qualifications  Achieved GCSEs or equivalent  Completed an apprenticeship  Achieved AS, A Level or equivalent  Achieved NVQ or equivalent  Achieved a qualification at degree level or above  Prefer not to say |
| **Do you have any dependent children living in your household in the following age groups?**  0-10 11-17 18-21 No |
| **Which of the following best describes your usual employment status:**  Employed full-time  Employed part-time  Self-employed full-time  Self-employed part-time  Student  Looking after the family or home  Temporary sick  Long-term sick  Retired  Prefer not to say |
| **Which of the following forms of financial support do you currently receive or are in the process of applying for:**  Income support  Housing Benefit  Employment support allowance  Working Tax Credit  Pension Credit  Universal credit  Job Seekers Allowance  Council Tax Reduction  None of the above  Prefer not to say |
| **Are you currently or have you previously served in the UK Armed Forces?**  No  Yes - currently serving  Yes – previously served in Regular Armed Forces  Yes – previously served in Reserve Armed Forces |
| **First language**  **………………………………………………………..** |

**Section B – (Family Healthy Weight Referral)**

Child details:

|  |  |
| --- | --- |
| First Name: | Last Name: |
| Gender:  Female ☐ Male ☐ Other ☐ Prefer Not To Say ☐ | Date of birth: |

Parent details:

|  |  |  |
| --- | --- | --- |
| First Name: | | Last Name: |
| Address: | | |
| Postcode: | | Date of birth: |
| Telephone: | Consent for voicemail:  (please tick) | |
| Email address:  *If the patient has access to email, then this is essential for the referral process.* | | |

Eligibility criteria:

1. Please tick to confirm that the family meets the following criteria ☐

* Child is aged 5-17 years.
* Child has a BMI ≥91st centile with no co-morbidity *\*this must be a recent BMI\**
* Family is committed to complete a healthy weight intervention.
* Child or parent does not have a history of or an ongoing eating disorder.

Equalities monitoring:

|  |
| --- |
| **Child**  **Ethnic Origin**  ☐      Arab  **Asian/Asian British**  **☐** Bangladeshi  **☐** Indian  ☐      Pakistani  ☐      Chinese  ☐      Other, please state……………………  **Black/African/Caribbean/Black British**  **☐** African  ☐       Caribbean  ☐       Other, please state………………………    ☐       Gypsy or Traveller of Irish Heritage  **Mixed/Multiple Ethnic Groups**  ☐       White and Asian  ☐       White and Black African  ☐       White and Black Caribbean  ☐       Other, please state………………………  **White**  ☐       English/Welsh/Scottish/Northern Irish/British  ☐       White – Irish  ☐       White – Other, please state………………….  ☐       Other ethnic group  **Other**  **☐** Other ethnic group, please state………………  ☐       Prefer not to say |
| **Disability**  ☐   No  ☐   Yes – Physical impairment, such as *difficulty using arms or mobility issues which may mean using a wheelchair or crutches.*  ☐   Yes – Sensory impairment, *such as being blind / having a serious visual impairment*  *or being deaf / have a serious hearing impairment.*  ☐   Yes – Mental health condition, *such as depression, anxiety or schizophrenia.*  ☐   Yes – Learning disability/difficulty, *such as Down’s Syndrome, dyslexia, dyspraxia or cognitive impairment such as autistic spectrum disorder.*  ☐    Yes – Long standing illness or health condition, *such as cancer, HIV, diabetes, chronic heart disease or epilepsy.*  **☐**Yes – Other (please state) ………………………………………………………………………………..  ☐    Prefer not to say.  If yes, please tell us how this affects the way that your child accesses or uses services…………………………………………………………………………………………………………… |
| **Parent**  **Age:**  Under 1819-2425-4445-6465-74  Over 75  Prefer not to say |
| **Ethnic Origin:**  Arab  **Asian/Asian British**  Bangladeshi  Indian  Pakistani  Chinese  Other, please state……………………  **Black/African/Caribbean/Black British**  African  Caribbean  Other, please state………………………  Gypsy or Traveller of Irish Heritage  **Mixed/Multiple Ethnic Groups**  White and Asian  White and Black African  White and Black Caribbean  Other, please state………………………  **White**  English/Welsh/Scottish/Northern Irish/British  White – Irish  White – Other, please state………………….  Other ethnic group  **Other**  Other ethnic group, please state………………  Prefer not to say |
| **Gender:**  Female Male Other Prefer not to say |
| **Do you consider yourself to be disabled?**  No  Yes – Physical impairment, such as *difficulty using arms or mobility issues which may mean using a wheelchair or crutches.*  Yes – Sensory impairment, *such as being blind / having a serious visual impairment or being deaf / have a serious hearing impairment.*  Yes – Mental health condition, *such as depression, anxiety or schizophrenia.*  Yes – Learning disability/difficulty, *such as Down’s Syndrome, dyslexia, dyspraxia or cognitive impairment such as autistic spectrum disorder.*  Yes – Long standing illness or health condition, *such as cancer, HIV, diabetes, chronic heart disease or epilepsy.*  Yes – Other (please state) ………………………………………………………………………………  Prefer not to say.  If yes, please tell us how this affects the way that you access or use services…………………………………………………………………………………………………… |
| **Sexual Orientation**  Bisexual Gay man Gay woman/lesbian Heterosexual Other Prefer not to say |
| **Religion and/or Belief**  Buddhist Christian Hindu Jewish Muslim Sikh  No religion  Any other religion, please state…………. Prefer not to say |
| **Do you identify as a transgender person?**  Yes No Prefer not to say |
| **Which of the following describes your highest level of qualification?**  No qualifications  Achieved GCSEs or equivalent  Completed an apprenticeship  Achieved AS, A Level or equivalent  Achieved NVQ or equivalent  Achieved a qualification at degree level or above  Prefer not to say |
| **Do you have any dependent children living in your household in the following age groups?**  0-10 11-17 18-21 No |
| **Which of the following best describes your usual employment status:**  Employed full-time  Employed part-time  Self-employed full-time  Self-employed part-time  Student  Looking after the family or home  Temporary sick  Long-term sick  Retired  Prefer not to say |
| **Which of the following forms of financial support do you currently receive or are in the process of applying for:**  Income support  Housing Benefit  Employment support allowance  Working Tax Credit  Pension Credit  Universal credit  Job Seekers Allowance  Council Tax Reduction  None of the above  Prefer not to say |
| **Are you currently or have you previously served in the UK Armed Forces?**  No  Yes - currently serving  Yes – previously served in Regular Armed Forces  Yes – previously served in Reserve Armed Forces |
| **First language**  **………………………………………………………..** |

**Section C – (Adult or Family referral)**

This section must be completed and signed by a registered healthcare professional.

I recommend the above patient/family participate in a healthy weight programme offered by the Public Health and Wellbeing Division (PHWD) at South Gloucestershire Council (SGC). I confirm that I have assessed this patient/family who to my knowledge meet the appropriate referral criteria and that there is no medical reason why they should not participate. I confirm that I will keep the PHWD at SGC updated with any relevant health changes and that I have discussed the service, the Privacy Notice (Section D – Information for patients) and the patient/family has given verbal consent for this referral.

|  |
| --- |
| Name of referring healthcare professional (print):  Please tick: GP ☐ PN ☐ |
| Signed: |
| Surgery/Health Centre: |
| Date letter merged: |

Once the referral form has been completed, please give a copy to the patient (including Section D) and securely email the form to [OneYou@southglos.gov.uk.](mailto:OneYou@southglos.gov.uk)

**Section D – Information for patients**

**What is healthy weight on referral?**

This is a local service that helps people to achieve a healthier weight by offering support with navigating healthy weight services. The service is a partnership between South Gloucestershire Council and locally commissioned service providers.

The service can also signpost to physical activities and other appropriate services via One You South Gloucestershire (OYSG). The aim of the service is to provide you with the skills, knowledge and confidence to help you or your family achieve a healthier weight more effectively.

**How much does it cost?**

There is no cost associated with this referral and the services offered are free of charge.

**What happens next?**

Once your healthcare professional has completed the referral form it will be sent to the One You South Gloucestershire team at SGC. TheOYSG team will then contact you via email or telephone to discuss the offer. If you have any questions in the meantime, please contact the OYSG team on  [01454 865337](tel:01454865337) or email[OneYou@southglos.gov.uk](mailto:OneYou@southglos.gov.uk)

**What do we do with your data?**

We will use your personal information to provide you with a service. We will share your personal information only with your referrer, and if appropriate locally commissioned healthy weight service providers, but no one else without your permission.

Upon completion of the service your personal information will be kept securely for 7 years and 20 years for child data.

Statistical information about people who use the service may be retained for longer than this, but this would not identify you.

If you would like to request access to the information we hold about you, or have any concerns about how we use your information please complete a [Data Subject Rights request form](http://www.southglos.gov.uk/documents/SARform.docx) or contact us at [OneYou@southglos.gov.uk](mailto:OneYou@southglos.gov.uk)

More information about how we manage your personal information is available from [www.southglos.gov.uk/privacy](http://www.southglos.gov.uk/privacy).

If you do not have a computer and would like more information, please contact the One You South Gloucestershire team on  [01454 865337](tel:01454865337).