mytime health

Mytime Health's Mytime Myway Referral Form

All patients MUST be motivated to lose weight

□ Tier 1 Community Cooks – self or direct referral- **Any BMI**
□ Tier 2 Community Based Weight Management- self or direct referral between **BMI 30- 35**
□ Tier 3 Specialist Weight Management Service – health practitioner referral **BMI ≥35 with comorbidities and ≥40 without comorbidities**

Exclusion Criteria: Women who are pregnant, patients with poorly controlled co-morbidities, patients under 18.

Patient Details

Name:.. NHS No..

Address:...

....Postcode:...

Home Tel no:.. Mobile Tel no:...

DOB:........................ Gender:.............................. Height...........cm Weight..........kg BMI..............kg/m²

Please tick box if any apply:

□ Type 1 Diabetes
□ Type 2 Diabetes
□ Dyslipidaemia
□ Hypertension
□ Cardiovascular disease
□ Sleep apnoea
□ Pre bariatric surgery □ Post bariatric surgery
□ Breastfeeding
□ Diagnosed mental health condition
please specify...
□ Other - please specify......................................
□ Disability- please specify ....

Has the patient been through the service in the past 12 months? Yes □ No □ Please Specify...
Is the patient motivated to lose weight? Yes □ No □

GP Details (patient must be registered with GP from Norfolk or Waveney)

Name of GP:..Contact tel no:......................................

GP Address:...Postcode:..........................

Relevant Medication

Please list any relevant medication or attach a prescription list::..

Referrer Consent

Print Name...**Signature:**.. **Date:**......................................

TIER 3 ONLY: Relevant Recent Measurements/ Blood Results

Please tick box if any apply or attach recent blood results:

□ Fasting Blood Glucose:	_______	Date:	□ HbA1c:	______	Date:
□ Cholesterol:	_______	Date:	□ LDL:	______	Date:
□ TG:	_______	Date:	□ HDL	______	Date:
□ Blood Pressure:	_______	Date:	□ U&E	______	Date
□ TSH:	_______	Date:	□ Hb	______	Date

Weight: ____________ **BMI:** ____________ **Date:** ____________

Statement of Consent (To be completed by the patient)

- I agree to be involved in Mytime Health's Mytime Myway and have received relevant information about the structure of this service, and data collected.
- I agree to be contacted for follow up purposes on regular intervals for up to 1 year.
- I understand that my data will be stored on paper and electronically on a secure database, in accordance with the Data Protection Act and NHS Information Governance.
- I agree for my data to be shared with Mytime Health, NHS Norfolk and Waveney and The University of East Anglia for evaluation purposes. (This will also apply when commissioning of the service moves to Norfolk and Waveney County Council).

Print Name...**Signature:**.. **Date:**......................................

Please send completed form to relevant address or fax number given below:
1 Common Lane North, BECCLES, Suffolk NR 34 9BN
Mobile 07720 599878 **Fax** 01502440696 **Email:** myway@mytimehealth.co.uk

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□ Triage complete □ Referral to Tier 1 □ Referral to Tier 2 □ Referral to Tier 3 □ Inappropriate referral / Referrer informed

Mytime MDT Staff Name.................................... **Signature:**...................................... **Date:**....................................