Adult Weight Management Programme Referral Form

Waikato Regional Diabetes Service

Patient Surname:	NHI:
Given Names:	DOB:
Address:	GP:
Contact phone numbers:	

Note: We do not accept patients who are currently pregnant or lactating or younger than 18 y/o.

Reason for referral:

BMI: ______ **or Weight:** ______ **& Height:** ______

Prediabetes [] FPG ≥ 5.6 mmol or [] 2 hr GTT ≥ 7.8 mmol

Type 2 diabetes treated with

[] diet [] oral meds []insulin

Year of diagnosis of type 2 diabetes______

What was the last HBA1c?_______ **Date:**_______

Please indicate if your patient also has any of the following illnesses:

[] Obstructive Sleep Apnoea or Obesity Hypoventilation Syndrome
[] Ischaemic Heart Disease
[] Congestive Heart Failure
[] Cerebral Vascular Event
[] Hypertension
[] Dyslipidaemia If so, what was the last fasting lipid profile?
LDL: ________ HDL: ________ TG: ________
[] Renal Insufficiency If so, what was the last serum creatinine? ________
[] Liver Disease ________ If so, what was the last serum?
AST/ALT: ___/___ GGT: ________ Alk Phos: ________ Tot. Bili: ________
[] PCOS
[] Gout
[] Osteoarthritis that significantly limits physical activity
[] Depression
[] Eating Disorder
[] Binge [] Bulimia Other ________________

Is your patient required to lose weight to undergo surgery? **[]Yes** **[] No**

If yes, for what type of surgery? ________________

Please comment on any other medical illness:

P.T.O

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Other comments:

Print Referrer/GP
Name & Practice Address

Signature

Date

☐ **PLEASE CHECK THAT ALL PATIENT CONTACT INFORMATION IS UP TO DATE AND CORRECT**

☐ **PATIENT IS SUITABLE FOR A GROUP ENVIRONMENT**

☐ **PATIENT IS AWARE AND AGREES WITH REFERRAL**

☐ **PATIENT IS AWARE THAT OPTIFAST MEAL REPLACEMENT IS USED AND HAS A COST (~$80.00/wk in place of usual cost of food)**

Please send referral to the Waikato Regional Diabetes Clinic

Address:
Waikato Regional Diabetes Service
Private Bag 3200
Hamilton 3240

Fax: 07 838 3788
Phone: 07 859 9180

Revised October 2021