**REFERRAL TO UNIVERSITY HOSPITALS TEES CEW CLINIC**

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| **Service Name** | **Paediatric CEW Clinic (Complications from Excess Weight)** |
| **Service Location** | The James Cook University Hospital   |
| **Age Range Treated** | 1-17 years  |
| **Referral criteria** | Patients with BMI >3.5 SDS or BMI>99.6th centile and at least one identified complication of obesity. |
| **Service description** | Patient centred multidisciplinary specialist tier 3 paediatric obesity service providing package of care for 12 months duration.Investigation for underlying cause of obesity if required.Management of secondary complications Service includes specialist nurse, psychology, dietetics, physiotherapy, paediatricians and family support worker. |
| **Exclusions** | BMI under 99.6th centile, under 1 year or over 18 years of ageAny patient who has not had screening investigations. |
| **Mandatory Investigations and information required**  | Height, Weight and BMI, Blood PressureHbA1c, U&E, LFT, Bone profile, free T4, TSH, Lipid Profile, Fasting insulin, Fasting glucose. |
| **Referral Notes** | Please include details of secondary complications, PMH and whether evidence of learning difficulties or autistic spectrum disorder in the referral.Complications secondary to weight include: Type 2 diabetes, PCOS, hypertension, NAFLD, obstructive sleep apnoea, severe psychological distress, intracranial hypertension, impaired mobility secondary to weight. |
| **Alternative Services** | Referrals to specialist services will be completed if secondary complications are identified.  |
| **Instructions to Patients** | The service will provide various options out of hospital to support families including education sessions, activities and home visits.Clinic appointments which will be held in the Children's Outpatient Department at The James Cook University Hospital via the South Entrance. |

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| Name and location of referrer |  |
| Date of Referral |  |
| Patient’s First name |  |
| Patient’s Surname |  |
| DOB |  |
| NHS Number |  |
| Address |  |
| Postcode |  |
| Contact number of carer |  |
| Is patient between 1 and 18 years at point of referral? |  |
| Has the patient/family had tier 2 weight management provision? e.g. HENRY/Growing well growing healthy |  |
| Is interpreter required & what language? |  |
| **INVESTIGATION RESULTS** | Date of measurement | Result |
| Weight (kg) |  |  |
| Height (cm) |  |  |
| BMI  |  |  |
| Blood pressure  |  | Systolic |  |
|  |  | Diastolic |  |
| ALT (U/l) |  |  |
| AST (U/l) |  |  |
| Fasting insulin (pmol/l) |  |  |
| Fasting glucose (mmol/l) |  |  |
| HbA1c (mmol/mol) |  |  |
| OGTT result (If undertaken)\* | 0 minutes |  |  |
| 120 minutes |  |  |
| Fasting Lipids: |  |  |
| Cholesterol (nmol/l) |  |  |
| Triglycerides (nmol/l) |  |  |
| HDL cholesterol (mmol/l), if available \* |  |  |
| Calculated LDL (mmol/l), if available \* |  |  |
| T4 (pmol/l) |  |  |
| TSH (mIU/l) |  |  |
| Any other relevant investigations |  |  |

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| **CO-MORBIDITIES RELATED TO EXCESS WEIGHT – Please provide supportive evidence where stated** | Please tick. Yes/No | Details |
| **Obstructive Sleep Apnoea**Results of overnight oximetry, polysomnography, is the patient on overnight CPAP, or under a respiratory physician?  |  |  |
| **Idiopathic intracranial Hypertension**Has the child had a lumbar puncture to confirm diagnosis? |  |  |
| **Polycystic Ovarian Syndrome.** Preferably this should not be diagnosed within 2 years of menarche. Clinical features should be supported by biochemical evidence of raised free androgen index (testosterone/SHBG x 100). Please give result, clinical features and age at menarche. |  |  |
| **Non-alcoholic Fatty Liver Disease** |  |  |
| **Hypertension** supported by 24hr BP monitoring, or regular home BP monitoring. Give details. |  |  |
| **Dyslipidaemia –** Please give details |  |  |
| **Psychosocial complications of excessive weight** eg bullying, low self-esteem, self-harm, social isolation, anxiety, depression, effect on education. If formal **CAMHS** involvement please indicate |  |  |
| **Significant joint, mobility or orthopaedic problems.** Give details. |  |  |
| **Safeguarding concerns** |  |  |
| **Any other diagnoses** |  |  |
| **Other supporting information** |  |  |

All information is essential for the referral to be considered, except those fields marked with an **\***

Please send referrals to: stees.cewservice@nhs.net