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**Application for an Individual Funding Request for referral to the Weight Management Service at the Royal United Hospital.**

**Bath & North East Somerset CCG does not directly commission bariatric surgery. Any patient meeting the criteria is referred to the RUH specialist weight management service who will work with the patient and refer on if appropriate.**

**Please complete ALL details. By filling in this form you confirm that the patient has agreed to you sharing this data with BaNES CCG and the RUH.**

1. **PATIENT DETAILS**

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| **Last name:**  | **First name(s):**  |
| **Address:**  |
| **Gender: Male** [ ]  **Female** [ ]  | **Date of Birth:**  |
| **NHS Number:**  | **BMI:** |

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| **2. DETAILS OF GP** |
| **GP Name and Practice:**  |
| **Practice address:** **Tel no.**  |

1. **TREATMENT REQUESTED**

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|  **Specialist Weight Management Intervention (including potential bariatric surgery 🞏** **Post-operative bariatric surgery support (including band fill) 🞏** |

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| 1. **PLEASE PROVIDE DETAILS OF THE PATIENTS HEALTH AND ANY ALTERNATIVE TREATMENTS THAT HAVE BEEN TRIED**
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| **Current BMI:****The patient has a BMI of 40kg/m2 or more, or between 35kg/m2 and 40 kg/m2 and other significant disease as listed below****Obesity related co-morbidities**1. **Established ischaemic heart disease 🞏**
2. **Type 2 diabetes 🞏**
3. **Obstructive sleep apnoea 🞏**
4. **Hypertension 🞏**
5. **Benign intracranial hypertension 🞏**
6. **History of transient ischaemic attacks or stroke 🞏**
7. **Severe lower limb major joint disease requiring orthopaedic intervention**

**which is precluded on safety grounds due to the patients BMI 🞏****Any other co-morbid condition(s)****Have any Obesity Drugs been tried?****Have any Weight Reduction programmes been tried?****(please attach evidence e.g. certificates from Slimming World/Weight Watchers)****Is the patient committed to the need for long term follow up?****Is the patient generally fit for anaesthesia and surgery?** |

**Please attach any information that may support this application i.e. specialist reports, clinic letters, test results.**

**SIGNATURE**

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| **Print name:** **Date:**  |

**Please return completed form and email to: bswccg.efr@nhs.net**