

# Welbeck Weight Management

Please complete all sections of the form. **By completing this form, you confirm you have the consent required to share this information.**

## PATIENT DETAILS

Title:	Forename:	Surname:
MRN:		
Date of birth:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other	
Residential address:		Postcode:
Telephone:	Mobile:	Email:
Height (cm):	Weight (kg):	Historic Max Weight (kg):

## MEDICAL HISTORY

Please indicate whether the patient has any of the following conditions, which will result in **patient exclusion from the Weight Management** service:

- |  |  |
|--|--|
| <input type="checkbox"/> Age > 80  | <input type="checkbox"/> Thyroid cancer (medullary thyroid carcinoma)        |
| <input type="checkbox"/> Type 1 Diabetes   | <input type="checkbox"/> Multiple endocrine neoplasia syndrome type 2 (MEN2) |
| <input type="checkbox"/> Severe gastrointestinal disorders (e.g., gastroparesis) | <input type="checkbox"/> Mental health related conditions                    |
| <input type="checkbox"/> Pancreatitis  | <input type="checkbox"/> Currently Pregnant                                  |

Please indicate if the patient has any other diagnosed conditions:

- |  |   |
|--|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Polycystic Ovary Syndrome (PCOS) |
| <input type="checkbox"/> High Cholesterol    | <input type="checkbox"/> Reproductive issues              |
| <input type="checkbox"/> Prediabetes         | <input type="checkbox"/> Fatty Liver Disease              |
| <input type="checkbox"/> Type 2 Diabetes     | <input type="checkbox"/> Sleep Apnoea                     |
| <input type="checkbox"/> Other:              |   |

## WEIGHT MANAGEMENT GOALS

- |  |  |
|--|--|
| <input type="checkbox"/> Weight Loss                   | <input type="checkbox"/> Improved Metabolic Health                     |
| <input type="checkbox"/> Prepare for Bariatric Surgery | <input type="checkbox"/> Reduction in Medication Dependence            |
| <input type="checkbox"/> Blood Sugar Control           | <input type="checkbox"/> Better Overall Well-being (e.g. Better sleep) |
| <input type="checkbox"/> Improve Fertility             | <input type="checkbox"/> Other:  |

## HAVE YOU ATTEMPTED ANY OF THE FOLLOWING FOR WEIGHT LOSS?

- |  |  |
|--|--|
| <input type="checkbox"/> Calorie-controlled diet | <input type="checkbox"/> Intermittent fasting                |
| <input type="checkbox"/> Exercise program        | <input type="checkbox"/> Prescription weight-loss medication |
| <input type="checkbox"/> Low-carb / Keto diet    | <input type="checkbox"/> Bariatric surgery                   |
| <input type="checkbox"/> Other:                  |  |

## ARE YOU CURRENTLY TAKING ANY OF THE FOLLOWING MEDICATIONS FOR WEIGHT LOSS OR DIABETES?

- |   |                                  |
|---|----------------------------------|
| <input type="checkbox"/> Metformin  | <input type="checkbox"/> Insulin |
| <input type="checkbox"/> GLP-1 RA (e.g., Ozempic, Wegovy, Saxenda, Trulicity, Mounjaro) | <input type="checkbox"/> Other:  |
| <input type="checkbox"/> None   |                                  |

## IF YOU ARE CURRENTLY TAKING GLP-1 MEDICATION, PLEASE SPECIFY WHICH ONE:

Drug:  
Duration:

## EXTRA REQUIREMENTS

Special equipment requirements:	Wheelchair access: <input type="checkbox"/> Yes
Interpreter required: <input type="checkbox"/> Yes, please confirm language:	Other:

Please attach the last clinic letter, any relevant test results and any additional documentation to this form & submit to us using the below email.

# Welbeck Weight Management

## REFERRER DETAILS

Gp/referrer name :	Gp/referrer practice :
Gp/referrer contact number:	Gp/referrer email:

## PAYMENT DETAILS (IF KNOWN)

TYPE: <input type="checkbox"/> Self-funding <input type="checkbox"/> Embassy <input type="checkbox"/> Other (please complete below sections as appropriate)	
Embassy:	Letter of guarantee: <input type="checkbox"/> Yes (please attach)

## Pricing Details:

- Diagnostics Package (£2,000) – A consultant-led assessment including comprehensive diagnostic testing and specialist initial consultation and review.
- Treatment Package (£2,000 per quarter) – Includes GLP-1 therapy where clinically indicated (inclusive of 15% patient discount), follow-up consultation with consultant, and repeat of selected core bloods. This package provides safe, evidence-based weight management with continuity of care.
- Optional Package Features:
  - Multiparametric MRI with cT1 scoring
    1. Body Composition Scan (£600) - Quantitative measurements of visceral, subcutaneous adipose tissue and skeletal muscle. Safe and noninvasive assessment with non-contrast MRI.
    2. Liver MultiScan (£1,460) - Precise measures of liver disease activity, fat, and iron content across the whole liver. Sensitive to dynamic change in disease activity. Recognized in clinical guidelines for MASH. May be combined with a baseline liver MRI (£1,540).
    3. Comprehensive CoverScan (£1,890) - Assessment of six organs and body composition in a single multiparametric scan. Identify organ damage and stratify patients. Inclusive of Body Composition & Liver.
  - Psychological & Dietetic Support
    1. Dietetic Foundations / Implementation Support (~£920) - Initial 1-hour consultation, plus 4-hour time bundle to be used over the 3-months led by a specialist bariatric dietitian team
    2. Psychology / Behaviour Change Support (~£1,040) - Initial 50-minute psychological assessment + 8 x 50-minute therapy sessions led by a specialist psychologist or other qualified mental healthcare professional
    3. Integrated Wraparound Support (~£2,500) – Tailored for more complex patients, a combination of Options (1) and (2) with additional time for MDT support

The following tests are included in the Welbeck Weight Management diagnostics package. If the patient has had any of these tests recently, please **untick** the relevant test(s) below. Where any test is excluded, a **15% flat discount** will be applied to the screening package cost.

## BLOOD TEST REQUESTED:

<input checked="" type="checkbox"/> FBC	<input checked="" type="checkbox"/> TSH	<input checked="" type="checkbox"/> Ferritin
<input checked="" type="checkbox"/> U&E	<input checked="" type="checkbox"/> Lipid profile	<input checked="" type="checkbox"/> Iron Studies
<input checked="" type="checkbox"/> LFT	<input checked="" type="checkbox"/> Lipoprotein(a)	<input checked="" type="checkbox"/> Vitamin D (25-OH)
<input checked="" type="checkbox"/> ELF test	<input checked="" type="checkbox"/> HbA1c	<input checked="" type="checkbox"/> Folate
<input checked="" type="checkbox"/> Amylase	<input checked="" type="checkbox"/> Vitamin B12	<input checked="" type="checkbox"/> Albumin
<input checked="" type="checkbox"/> Bone Profile		

## IMAGING TESTS REQUESTED:

<input checked="" type="checkbox"/> Abdominal and Gallbladder Ultrasound	<input checked="" type="checkbox"/> Thyroid Ultrasound
<input type="checkbox"/> Body Composition Scan	<input type="checkbox"/> CoverScan
<input type="checkbox"/> Liver MRI	<input type="checkbox"/> Liver MultiScan

I confirm that I have discussed the self-funding nature of this referral with the patient, including the approximate costs involved, and that the patient has expressed their wish to proceed on this basis.

Gp/referrer Name:	Signed:	Date:	Professional Reg No:
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Please attach the last clinic letter, any relevant test results and any additional documentation to this form & submit to us using the below email.