**West Midlands Familial Hypercholesterolaemia Service (WMFHS) Referral Form**

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| **Patient’s Surname:** | **Previous Surname (If known):** |
| **Forenames:** |
| **D.O.B:**  | **Age:** | **NHS No:** |
| **Address:** | **Postcode:** |
| **Telephone No. Daytime: Mobile:** |
| **Ethnicity:** |
| **Special Requirements (e.g. hearing loss, physical disability):** |
| **Spoken Language:** |
| **Interpreter Required (e.g. BSL, Language):** |
| **Has patient consented to referral: YES/NO** |

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| **Referral Date:**  | **Referring GP/Consultant** | **CCG/Trust:** | **GP Practice Code:** |
| **Address:** | **Post Code:** |
| **Tel No:** | **Email:** |

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| **LIPID RESULTS TO ACCOMPANY THE REFERRAL**  |
| **If on lipid lowering medication, state drug and dose:** |
| **Date: Total Chol: Triglycerides: HDL-C: LDL-C Fasting YES/NO** |
| **Patients with the following conditions are NOT eligible for referral to WMFHS (please see referral pathway):-*** **Diagnosis/Treatment for Nephrotic Syndrome**
* **Diagnosis/Treatment for CKD 4 and above**
* **Diagnosis/Treatment for Chronic Liver Disease**
* **Triglycerides > 5mmol/L**
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| **1st Degree relatives with proven CHD/Stroke < 60years**  | **YES/NO** |
| **2nd Degree Relatives with proven CHD/Stroke < 50 years (if known)** | **YES/NO** |
| **Family History of cholesterol >7.5 mmol/L** | **YES/NO** |
| **Blood Pressure****(Date):** | **Smoker/Ex-Smoker/****Non-smoker** | **Alcohol****(Units/week):** |
| **List patients current medication:** |
| **Relevant medical history (cardiovascular):** |
| **If this patient is found to be appropriate for referral to a Lipid Consultant this will be done DIRECTLY by the FH Specialist Nurse. If you DO NOT wish for us to refer directly please tick here**  |

**Incomplete forms will be returned**

**Please email completed forms and any additional information to** **Westmidlands.fhnurses@nhs.net**