**Referral to the National Severe Insulin Resistance Service**

Please complete the form using the text/check boxes.

**Date of referral**

**Referring Clinician**

|  |  |
| --- | --- |
| **Name:** |  |
| **Position:** |  |
| **Address:** |  |
| **Phone:** |  |
| **Email:** |  |

**Patient Details**

|  |  |
| --- | --- |
| **Name:** | **Date of birth:** |
| **NHS number:**  | **Address:** |
| **Gender:** | **Ethnicity:** |

**Brief History (including family history if relevant) and question to be answered**

|  |
| --- |
|  |

**Medication**

**Clinical Assessment**

|  |  |
| --- | --- |
| Weight(Kg): | BMI(kg/m2): |

|  |  |  |
| --- | --- | --- |
| Please check box if yes |  | Details if known |
| Confirmed genetic diagnosis  |  |  |
| Diabetes Mellitus  |  |  |
| Hepatic steatosis  |  |  |
| Hypertriglyceridaemia  |  |  |
| Acanthosis Nigricans  |  |  |
| Partial Lipodystrophy  |  |  |
| Generalised Lipodystrophy  |  |  |
| Hyperandrogenism  |  |  |

**Biochemical Assessment**

|  |  |  |  |
| --- | --- | --- | --- |
| **Parameter** | **Value** | **Units** | **Date tested** |
| HbA1c |  |  |  |
| Insulin (fasting Y/N) \* |  |  |  |
| C-peptide (fasting Y/N) \* |  |  |  |
| Glucose (fasting Y/N) |  |  |  |
| Triglyceride (fasting Y/N) |  |  |  |
| Alanine Aminotransferase |  |  |  |
| Gamma GT |  |  |  |
| Leptin\* |  |  |  |
| Adiponectin\* |  |  |  |
| \*These tests are not available in every referral centre, please include where available |

**Please return the completed form:**

|  |  |
| --- | --- |
| **By post** | **Or email** |
| National Severe Insulin Resistance ServiceMRC-Wellcome Trust Institute of Metabolic ScienceBox 281 Addenbrooke’s Treatment CentreAddenbrooke’s HospitalHills RoadCambridgeCB2 0QQUnited Kingdom | insulinresistanceservice@addenbrookes.nhs.uk**NB. if any patient identifying information is included please use email address below**add-tr.insulinresistance@nhs.net**Any questions? Please phone us**+44(0)1223 348123 |