



Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Referral Form



**Centre for Obesity
Management**

St. Columcille's Hospital

St Columcille's Hospital Centre for Obesity Management (SCH COM)
Loughlinstown
Dublin, D18 CX63

To be completed by Health Care Professionals

Referral Criteria:

- Body Mass Index (BMI) $>30 \text{ kg/m}^2$ with at least one obesity-related complication.
- Obesity treatment in the community has not been sufficiently effective, or the patient does not have access to treatment within the community.
- The patient is agreeable to the referral.
- The patient understands that this referral is for MDT Level 3 obesity care, in line with the HSE Model of Care for Management of Obesity in Ireland (2022). This service manages obesity as a chronic disease. The management plan will include consideration of appropriate medications, bariatric surgery and other interventions. It is important for the referring clinician & patient to understand that medications and/or surgery may not be appropriate in some cases.

Patients may not be suitable for COM referral if they:

- Have active psychiatric disease.
- Do not wish to attend the service.
- Are unable to travel to St. Columcille's Hospital (some appointments may be virtual but there will be a minimum number of in-person appointments).

Sleep Apnoea

There is a high risk of obstructive sleep apnoea (OSA) in patients living with obesity. OSA screening is mandatory as a work up for Bariatric Surgery. In order to avoid undue delays in this pathway, early referral to a sleep clinic is preferable.

We recommend referring the patient for assessment for Obstructive Sleep Apnoea.

Mental Health

The successful management of obesity as a chronic disease is improved by appropriate mental health support and therapy when appropriate. If your patient has a history of unresolved trauma, an active mood disorder or other mental health condition, please consider a referral to an appropriate service, such as the National Counselling Service (NCS) or local mental health service.

Bariatric Surgery

During the programme the multidisciplinary team will consider the suitability of each patient for Bariatric Surgery. If the patient is deemed safe and appropriate for a surgical procedure, and if they are agreeable to having surgery, they will be referred to the Bariatric Surgical team.

Check List:

- Fill out referral proforma below with as much detail as possible.
- Measure the weight and height to calculate BMI, and record it on the referral proforma (The referral will not be processed and will be returned if this step is incomplete).
- Post or email the referral form:
 - Email to: centralreferral.office@hse.ie
 - Post to: Central Referrals, St Columcille's Hospital, Loughlinstown, Dublin 18



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Referral Form

Date of Referral

____/____/____



**Centre for Obesity
Management**

St. Columcille's Hospital

Patient Details: First name: _____ Surname: _____

Address: _____

Telephone No: _____

Gender (Identify as;) Male Female Non-Binary **Email:** _____

Date of Birth ____/____/____. Weight _____kg. Height _____cm. BMI _____kg/m²

Current Medications: _____

OSA Referral Sent: Y / N Referral Centre: _____

IGT/Pre-Diabetes <input type="checkbox"/>	Type 2 Diabetes <input type="checkbox"/>	HbA1c above target on max meds <input type="checkbox"/>
	Type 1 Diabetes <input type="checkbox"/>	Retinopathy / Maculopathy <input type="checkbox"/>
	PCOS <input type="checkbox"/>	Infertility <input type="checkbox"/>
	Erectile Dysfunction <input type="checkbox"/>	
	Hypertension <input type="checkbox"/>	TIA / CVA <input type="checkbox"/>
	Dyslipidaemia <input type="checkbox"/>	Angina / MI <input type="checkbox"/>
		Heart Failure/Cardiomyopathy <input type="checkbox"/>
	Renal impairment <input type="checkbox"/>	End stage Renal disease/Dialysis <input type="checkbox"/>
OSA - CPAP not required <input type="checkbox"/>	OSA – CPAP required <input type="checkbox"/>	Shortness of Breath at rest <input type="checkbox"/>
	Asthma <input type="checkbox"/>	Obesity Hypoventilation Syndrome <input type="checkbox"/>
	COPD <input type="checkbox"/>	Oxygen Therapy <input type="checkbox"/>
Mild elevation LFTs <input type="checkbox"/>	MASLD <input type="checkbox"/>	Cirrhosis <input type="checkbox"/>
GORD <input type="checkbox"/>	Symptomatic Gallstones <input type="checkbox"/>	End stage Liver disease <input type="checkbox"/>
	Pre-cancerous condition / Dysplasia <input type="checkbox"/>	Obesity-related Cancer: GI/ Liver/Renal/Breast/Endometrial <input type="checkbox"/>
Low Mood <input type="checkbox"/>	Depression / Anxiety disorder <input type="checkbox"/>	Severe mental illness <input type="checkbox"/>
Cognitive impairment / Learning difficulties <input type="checkbox"/>	Binge Eating Disorder / Night-Eating Syndrome <input type="checkbox"/>	
Social Isolation <input type="checkbox"/>		
Psoriasis <input type="checkbox"/>	Hydradenitis Suppurativa <input type="checkbox"/>	Lymphoedema <input type="checkbox"/>
	PVD / Leg Ulceration <input type="checkbox"/>	Amputation <input type="checkbox"/>
Back/Joint pain <input type="checkbox"/>	Arthritis <input type="checkbox"/>	Joint replacement required <input type="checkbox"/>
Minor limitations ADLs <input type="checkbox"/>	Moderate limitations in ADLs <input type="checkbox"/>	Walking aid/Wheelchair <input type="checkbox"/>
		Unable to work / Disability <input type="checkbox"/>
		House-bound <input type="checkbox"/>
Migraine <input type="checkbox"/>	Intracranial Hypertension (ICH) <input type="checkbox"/>	ICH with visual impairment risk <input type="checkbox"/>
		Hx of venous thrombosis (VTE) <input type="checkbox"/>
		Recurrent unprovoked VTE <input type="checkbox"/>

Additional relevant medical history: _____

Referring Clinician : _____

Clinicians Address : _____

GP (if not the referrer): _____