Referral Form for Weight Management Service

Weight Management Service,
St Columcille's Hospital, Dublin 18
Eircode: D18 E365

To be completed by Health Care Professionals

Referral Criteria:

- Have a Body Mass Index (BMI) >40 kg/m^2
- Have a BMI >35kg/m^2 **plus** at least one weight-related co-morbidity
- Have previously tried community-based weight management programmes
- Are interested in attending a medical weight management programme

Patients may not be suitable if they:

- Have active psychiatric disease
- Do not wish to participate in a medical weight management programme
- Are unable to travel to St Columcille's Hospital on a monthly basis (approx 10 appointments over a 1 year period)

Sleep Apnoea

The risk of obstructive sleep apnoea (OSA) correlates strongly with BMI, with prevalence rates of over 60% in patients living with obesity.

Effective management of weight and metabolic health is difficult in the context of undiagnosed and/or untreated OSA. In addition, OSA screening is mandatory as a work up to Bariatric Surgery. In order to avoid undue delays in this pathway, early referral to a sleep centre is preferable.

Please strongly consider referring the patient for assessment for Obstructive Sleep Apnoea.

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 weight-related surgical procedure they will be referred to the Bariatric Surgical team.

Check List:

- Please fill out the referral proforma below with as much detail as possible
- **Measure the patient's weight, height and 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, D18 E365

St Columcille's Hospital Weight Management Service - Referral Form

Referring Clinician:_____

Clinician's Address:_____

_____

GP (if not the referrer): _____

_____

Patient Details

First name: _____ Surname: _____

Address:_____

_____

Telephone No:_____ * **Email address *:** _____ *** very helpful for communication**

Gender (Identify as;) Male ☐ Female ☐ Non-binary ☐ Agender ☐

Date of Birth: _____ / _____ / _____ Weight: _____kg Height: _____cm BMI:_____kg/m^2

Current Medications: _____

_____

OSA Referral Sent: Y / N Referral Centre: _____

IGT/Pre-Diabetes ☐	Type 2 Diabetes ☐ Type 1 Diabetes ☐	HbA1c above target on max meds ☐ Retinopathy / Maculopathy ☐
	PCOS ☐ Erectile Dysfunction ☐	Infertility ☐
	Hypertension ☐ Dyslipidaemia ☐	TIA / CVA ☐ Angina / MI ☐ Heart Failure/Cardiomyopathy ☐
	Renal impairment ☐	End stage Renal disease/Dialysis ☐
OSA - CPAP not required ☐	OSA – CPAP required ☐ Asthma ☐ COPD ☐	Shortness of Breath at rest ☐ Obesity Hypoventilation Syndrome ☐ Oxygen Therapy ☐
Mild elevation LFTs ☐ GORD ☐	NAFLD ☐ Symptomatic Gallstones ☐	Cirrhosis ☐ End stage Liver disease ☐
	Pre-cancerous condition / Dysplasia ☐	Obesity-related Cancer: GI/ Liver/Renal/Breast/Endometrial ☐
Low mood ☐ Poor self esteem ☐ Social Isolation ☐ Cognitive impairment / Learning difficulties ☐	Depression ☐ Anxiety disorder ☐ Binge Eating Disorder ☐ Night-Eating Syndrome ☐	Severe mental illness ☐
Psoriasis ☐	Hydradenitis Suppurativa ☐ PVD / Leg Ulceration ☐	Lymphoedema ☐ Amputation ☐
Back/Joint pain ☐	Arthritis ☐	Joint replacement required ☐
Minor limitations ADLs ☐	Moderate limitations in ADLs ☐ Walking aid required ☐ Unable to work / Disability ☐	Wheelchair required ☐ House-bound ☐

Other relevant medical condition _____