Any incomplete forms will be returned. We are not commissioned to see patients with a diagnosis of Asthma. Please email this form to medch.respiratory@nhs.net

|  |  |  |
| --- | --- | --- |
| **Diagnosis (must be completed)** | Bronchiectasis **** Interstitial lung disease  **** | COPD ****Emphysema ****  |
| **Spirometry results: (required)** | \*Referral will only be accepted with an attachment, with full spirometry results (inc graphs) from the last 12 months |
| **Recent chest x-ray / CT results** |  |
| **Reason for referral:** | Assessment **** Pulmonary rehabilitation **** |
| **Date of referral:** |  |
| **Referred by:** (Name/Job Role/Contact No) |  |
| **Patient name:** |  | **GP name:** |  |
| **Patient address:****Post code:** |  | **GP address:****Postcode:** |  |
| **Telephone number:** |  | **Telephone number - main:** |  |
| **Date of birth:** |  | **Telephone number – bypass/ex-d:** |  |
| **NHS number:** |  | **Fax number:** |  |
| **Date last seen:** |  | **Seen by:** |  |
| **Patient lives:** | Alone / Partner / Relatives / Warden / Nursing home |
| **Is the patient aware of this referral?** | Yes / No |
| **Brief patient details/medical history:** |
| **Current problem or relevant history:** |  |
| **Other medical history:** |  |
| **On inhalers? Yes / No** **Nebuliser? Yes / No** | **Please list all current inhalers / Nebs:** |
| **Oxygen? Yes / No** | **Please give details i.e Cylinders / Concentrator / Usage** |
| **Smoking history? Yes / No** | **If yes****Age started smoking -****Age stopped –** **Pack history -**  |
| **Cardiac history? Yes / No**  | **Further info:** |
| **Infection control status:** | **MRSA: Positive/ Negative. Date of Screen:** **Recent history of vomiting or diarrhoea: Yes/ No.****Other Infectious diseases e.g scabies/ shingles.** |
| **Additional comments to ensure the home visit is safe: i.e Any known risk to area and any history of patient/relative/person at property being aggressive, being under the influence of drink or drugs or refusing treatment** |