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** | | | | | | | | |