 **COMMUNITY RESPIRATORY TEAM REFERRAL FORM**

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| Title Mr / Mrs / Miss / Ms  Surname | First Name | GP Name | GP Tel No: |
| Address  Postcode | Date of Birth / /  Male Female | GP Surgery Address |  |
| Tel No | HCN: | NOK: | NOK Tel No: |

ACCEPTED: **COPD, BRONCHIECTASIS, ILD/PULMONARY FIBROSIS, OXYGEN ASSESSMENT**

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| Urgent / Routine  1-2 weeks / 4-6 weeks  **Please telephone team with urgent referrals** | Reason for Referral:  Long term Disease Mx Prevention of Admission  Pulmonary Rehab  Oxygen Assessment |
| **Referral to Oxygen Service Must Complete: (non- respiratory conditions accepted for O2 Assessment)**  COPD Pulmonary Fibrosis Bronchiectasis OSA Heart Failure Palliative Neuromuscular  Other Please state\_\_\_\_\_\_\_\_\_\_  Has current treatment been maximised? Yes No  Is patient without exacerbation 5-6 weeks? Yes No | |

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| Respiratory Diagnosis:  Confirmed / unconfirmed (select)  Respiratory Consultant known to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Presenting condition/reason for referral:  ***Patients with neurological condition need referred to respiratory consultant first:*** *Date referred*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| SpO2: % R/A or O2\_\_\_\_  Resp Rate:  B/P:  Pulse:  Temp: | | Past medical history: | |  | | |
| Nebuliser Yes No | | Oxygen: Concentrator \_\_\_L/min Cylinder \_\_\_L/min | | | | |
| Relevant medication: | |  | |  | | |
| ABG: RA/ \_\_\_\_\_\_\_\_O2  pH:  PCO2:  P02:  HCO3:  BE: | | WBC:  CRP:  CXR: | | FEV1: actual: \_\_\_\_\_ L, \_\_\_\_\_%pred  FVC: actual: \_\_\_\_\_ L, \_\_\_\_\_%pred  FEV1/FVC ratio: \_\_\_\_\_\_%  Smoking status: Yes / No / Ex  If ex-smoker for how long: | | |
| Referrer: Print Name: |  | | Signature: | |  |
| Designation: |  | | Contact Tel No: | |  |
| Referrer Address/email | | | | | |
| Date of Referral: | | | | | |

**CONTACT DETAILS**

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| **AREA** | **Telephone No** | **Mobile No** | **Email** |
| **Craigavon & Banbridge** | 028 3756 3168 | 0746 449 3672 | [**copdcb.referrals@southerntrust.hscni.net**](mailto:copdcb.referrals@southerntrust.hscni.net) |
| **Armagh & Dungannon** | 028 3756 4935 | 0746 449 3950 | [**copdad.referrals@southerntrust.hscni.net**](mailto:copdad.referrals@southerntrust.hscni.net) |
| **Newry & Mourne** | 028 37567164 | 0746 449 3951 | [**copdnm.referrals@southerntrust.hscni.net**](mailto:copdnm.referrals@southerntrust.hscni.net) |

 **COMMUNITY RESPIRATORY TEAM REFERRAL GUIDELINES**

**The Community Respiratory Team will assess each client for suitability for the service**

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| **Service Area** | **Inclusion Criteria** | | **Exclusion Criteria** | |
| **Long Term Disease management** includes:   * High risk of re-exacerbation * On Long-term Oxygen Therapy.   **Exacerbation Management** includes:   * Acute exacerbation * Chest infection * Prevention of admission | Diagnosis of:   * COPD * Bronchiectasis * Interstitial Lung Disease   Confirmed by Spirometry / CT scan  Spirometry results to be sent with referral | | * Those without a respiratory diagnosis will not be accepted * Severe acute asthmatics * Neurological patients * Patients with haemoptysis * Severe hypoxia * Haemodynamically unstable / Tachycardia (>120bpm) * Acute type 2 respiratory Failure * Impaired consciousness * Suspected lung cancer or TB * Acute Pulmonary oedema * Social issues or needs unable to be meet in community | |
| **Pulmonary Rehabilitation** | Diagnosis of:   * COPD * Bronchiectasis * Interstitial Lung Disease   Confirmed by Spirometry / CT scan.  Spirometry results to be sent with referral  FEV1 < 50% pred +/- MRC >3 (mMRC>2). | | * Activity limited by locomotor problems or cognitive impairment. * Apathy/ not motivate. * Unstable Angina or decompensated Heart Failure. * Embolism or MI within the past 6 weeks. * 2nd or 3rd degree heart block * DVT at present. * Contraindications: * Metastatic cancer * Unstable asthma * Unstable hypertension * SpO2 <90% | |
| **Home Oxygen Assessment and Review**  **(HOSAR)** | * Patient’s medical treatment must be maximised. * Patients with SpO2 <92% on room air consider referral for oxygen assessment. * Patients with SpO2<94% on room air and in the presence of peripheral oedema, evidence of pulmonary hypertension, secondary polycythaemia or ankle oedema consider referral for oxygen assessment | | * Oxygen is not recommended for those who are still smoking, given the high risk of fire. * Patients with neurological condition must be seen by a respiratory consultant before referral. * Patient must be without exacerbation for 5-6 weeks and clinically stable. | |
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| **Prevention of admission** | | **Urgent referral** | | **Routine referral** |
| to be seen within 24 hours | | will be seen within 1-2 weeks | | will be seen within 4-6 weeks or sooner if service permits |

**PLEASE ENSURE PATIENT IS AWARE AND HAS CONSENTED TO THE REFERRAL**

**Office Hours: Monday to Friday 09.00-17.00**