 **COMMUNITY RESPIRATORY TEAM REFERRAL FORM**

|  |  |  |  |
| --- | --- | --- | --- |
| Title Mr / Mrs / Miss / MsSurname | First Name | GP Name | GP Tel No: |
| AddressPostcode | Date of Birth / /Male Female  | GP Surgery Address |  |
| Tel No | HCN: | NOK: | NOK Tel No: |

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

|  |  |
| --- | --- |
| Urgent / Routine1-2 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 NeuromuscularOther Please state\_\_\_\_\_\_\_\_\_\_Has current treatment been maximised? Yes NoIs patient without exacerbation 5-6 weeks? Yes No |

|  |  |
| --- | --- |
| 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/ \_\_\_\_\_\_\_\_O2pH:PCO2:P02:HCO3:BE: | WBC:CRP:CXR: | FEV1: actual: \_\_\_\_\_ L, \_\_\_\_\_%predFVC: actual: \_\_\_\_\_ L, \_\_\_\_\_%predFEV1/FVC ratio: \_\_\_\_\_\_%Smoking status: Yes / No / ExIf ex-smoker for how long: |
| Referrer: Print Name: |  |  Signature: |  |
|  Designation: |  |  Contact Tel No: |  |
| Referrer Address/email |
| Date of Referral: |

**CONTACT DETAILS**

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

 **COMMUNITY RESPIRATORY TEAM REFERRAL GUIDELINES**

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

|  |  |  |
| --- | --- | --- |
| **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 referralFEV1 < 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.
 |
|  |  |  |
| **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**