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| **Patient Details** | **GP Details** |
| **Name:****Address:** **Telephone No:****NHS No:****DOB:****NOK details:** | **GP Name:****Surgery:****Contact Details:****Referrer Name:****Referrer Role:****Referrer Contact Number:** |
| **Diagnosis:****Consultant:** | **Co-morbidities** **(including Anxiety)**:**Known to Community/Palliative care/other:** |
| **Reason for Referral** |
| **West Hampshire Pulmonary Rehab****\*\* Currently not provided by Southern Health in North Hampshire. Please refer to Solent NHS Trust in the usual way \*\*** |
| **Oxygen** (patient must be stable): New assessment Review of current use  LTOT Ambulatory Saturations at rest: Saturations on exertion:**ABG on Air:** **ABG readings on …..l/m oxygen:**Current oxygen Usage (flow rate/hours):Current equipment:Evidence of Pulmonary Hypertension, Heart Failure or Secondary Polycythemia: Yes No  Inhalers optimally prescribed: Yes No   |
| **West Hampshire Admission Avoidance and Supported Discharge Referrals****\*\* Currently not available for North Hampshire CCG patients \*\***Patients must have a confirmed diagnosis of COPD in order to be accepted into the service.Referrals must be made via the clinical telephone triage line ONLY. **Please call 0300 003 0397**(For Southampton and surrounding areas please contact: 02381 204358)This service is available 7 days per week 8.30am to 4.30pm. Clinical triage will confirm service capacity to accept patient and discuss referral. The service is unable to take responsibility for the patient until either a discharge summary (supported discharge) or a visit encounter (Admission Avoidance) is received.Exclusion Criteria: Pneumonia, Uncontrolled co-morbidities, Suspected Pulmonary embolism, Acute asthma |
| **General Information required for all patient referrals** |
| **Medication**: oral/inhaled/nebulised/allergies |

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| **Relevant Investigations:**Last Spirometry (with date)FEV1/FVC Ratio:FEV1 % Predicted:FVC % Predicted:Other | **Current smoking status:** Pack year history:Referred to Smoke Free Hampshire: Yes / No  |
| Any further info required prior to seeing patientCarer/family required to be present | Current activity levelAnxietyIs patient able to attend clinic? |
| Observations |
| BP  | HR  |
| SPO2 | Temp |
| RR |  |
| Additional Information |
| Most Recent CXR Findings : Bloods: |
| LONE WORKER: I confirm that it is safe for staff to visit the patient at home alone Yes / No |

Signed: Date

Print Name: Designation:

**We have weekly MDT meetings in each area. Please call if you would like to attend.**