|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Contact Details for the services | | | | | | | | | | | | |
| **Outpatients Booking Office:** | | | **0300 003 0806** | | | | | | | | | |
| **Referral via eRS only** | | | | | | | | | | | | |
| Patient’s details | | | | | | | Patient’s background and culture | | | | | |
| Name | Full Name | | | | | | Ethnicity | | Ethnic Origin | | | |
|  |  | | | | | | 1st language | | Main Language | | | |
| DOB | Date of Birth | | | Age | Age | | Interpreter required? Interpreter required | | | | | |
| Sex | Gender(full) | | | | | | Military Veteran? | | | | | |
| Address & postcode | Home Full Address (stacked) | | | | | | Referrer details | | | | | |
|  |  | | | | | | Referring Clinician | |  | | | |
|  |  | | | | | | Practice ODS Code  Address | |  | | | |
|  |  | | | | | |  | | Organisation Name  Organisation Full Address (stacked) | | | |
| NHS No | NHS Number | | | | | | Tel no | | Organisation Telephone Number | | | |
| Hospital No | Hospital Number | | | | | | Email | | Organisation E-mail Address | | | |
| Home tel | Patient Home Telephone | | | | | | Referral date | | Short date letter merged | | | |
| Work tel | Patient Work Telephone | | | | | | Date received | |  | | | |
| Mobile tel | Patient Mobile Telephone | | | | | |  | |  | | | |
| Email | Patient E-mail Address | | | | | |  | |  | | | |
| Preferred contact method | | Home | | | |  | Work |  | Mobile |  | E-mail |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Social Information** | | | | | | |
| Social Context | Transport Issues | Has a Carer | | Is a Carer | | Lives Alone |
|  | Interpreter required | State which Language | | |  | |
| Next of Kin |  | | | | | |
| Relationship to Patient |  | | Telephone No | |  | |

|  |  |  |
| --- | --- | --- |
| **Reason for referral** | | |
|  | | |
| **Investigations required** | **Smoking status** | |
| Please tick requirements  Spirometry  Spirometry with reversibility  Salbutamol 400mcg inhaler via spacer  By filling out this order for the reversibility test you are authorising the administration of the medications by the physiologist/nurse. Please note it is the referrer’s responsibility to prescribe Salbutamol 100mcg x 4 puffs and aero chamber for the purpose of the test.  **PLEASE CONFIRM THAT THE GP GIVES AUTHORISATION FOR THE MEDICATION TO BE GIVEN AS PER THE ABOVE**  You must be authorised prescriber to request the reversibility. | Never |  |
|  | Current |  |
|  | How may a day? |  |
|  | How many years? |  |
|  | Ex-smoker |  |
|  | How many years has the patient not smoked? |  |
|  |  | |
| Details of past medical history  e.g. TB/Hepatitis | | |