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| 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 CodeAddress |        |
|  |  |  | 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 | **[ ]**  |

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| **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 |       |

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| **Reason for referral** |
|  |
| **Investigations required** | **Smoking status** |
| Please tick requirementsSpirometry **[ ]** 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 historye.g. TB/Hepatitis |