**Referral to Lung Function & Sleep Department - QEHB**

Email completed form to: [uhb-tr.lfsadmin@nhs.net](mailto:uhb-tr.lfsadmin@nhs.net) or Fax completed form to: 0121 460 5822

Telephone for enquiries: 0121 371 3870

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Patient** | | **Referrer details** | | |
| Name:  DOB:  Address: | | Name:  Practice Name:  Telephone: | | |
| NHS No Click here to enter text. | | Hospital No | | |
| **Symptoms** | | **Reason for Referral** | |
| **Respiratory**  Dyspnoea  Cough  Sputum  Wheeze  Cyanosis  Other: | **Sleep**  Daytime sleepiness  Snoring  Witnessed apnoeas | **Diagnostic**  ?COPD  ?Asthma  ?Restrictive  ?OSA  Other: | **Monitoring**  Known COPD  Known Asthma  Known restrictive disease |

|  |  |
| --- | --- |
| **Routine Diagnosis** | **Special Investigations** |
| **Spirometry +/- bronchodilator reversibility testing \***  **\***Where clinically appropriate a bronchodilator (from list below) will be delivered as per Lung Function protocols. By signing this referral, you are agreeing for any of these medications to be administered to the patient, unless contraindicated.   * Salbutamol 2.5mg or 5mg * Terbutaline 5mg * Ipratropium bromide 500microgram   **Capillary Blood Gases**  **Exhaled NO (FeNO)**  **Overnight Oximetry** (Screening test only. If a Sleep Specialist review is more appropriate please refer via e-referral to the sleep clinic directly) | **Assess for Long Term O2 Therapy\*\***  **Assess for Ambulatory O2 Therapy\*\***  **Assessment for Fitness to Fly\*\***  \*\*Oxygen will be administered. By signing this referral you are agreeing for oxygen to be administered  **Assessment for long term nebulised bronchodilators –** Prescription must be attached for referral to be processed (2/52 nebulised bronchodilators) |

|  |  |
| --- | --- |
| Infection Status – **if incomplete referral will be rejected** | **OFFICE USE ONLY** |
| MRSA YES  NO  HEPATITIS B YES  NO  HEPATITIS C YES  NO  TB YES  NO  Other Infection? (Please state): | Approved By:  Tests Approved: |

|  |
| --- |
| **Name of person completing form:**  **Position (must be medical/nurse prescriber):**  **Signed:**  **Date:** |

|  |
| --- |
| **INFORMATION:**  If a significant respiratory abnormality is discovered the lung function unit will proceed with further testing in accordance with UHBT policy, criteria listed below.  **Criteria for further lung function investigations:**  The following conditions should prompt Lung Function and Sleep to recommend GP referral to Respiratory Consultant. LF&S will proceed with investigations that are clinically appropriate and would be required for the secondary care consultation   * **COPD**   New diagnosis of very severe COPD (FEV1<30%) – never seen a respiratory physician.   * **Respiratory Failure**   New diagnosis of significant hypercapnic respiratory failure – CO2 >6.5ka – never seen a respiratory physician.   * **Restrictive lung disease**   New diagnosis of restrictive lung disease - never seen a respiratory physician.  **The following conditions should prompt Lung Function and Sleep to refer directly to Respiratory Consultant/ A&E and inform GP:**   * Detection of acidotic respiratory failure. * Other circumstances where the clinical situation requires this. |