**Pleural Procedures Admission Avoidance Clinic Guidance and Referral Form**

**When:** Tuesday afternoon and Friday

**Where:** Respiratory Outpatients, A221, Bristol Royal Infirmary

**Inclusion criteria:** Any adult patient with pleural disease that needs investigating. This includes pleural effusions, pneumothorax follow-up and pleural thickening.

**NB: The clinic is set up to perform diagnostic pleural taps and therapeutic pleural aspirations.**

**Any patient requiring a procedure must be physically capable of sitting on edge of trolley independently whilst procedure is performed**

**Exclusion criteria:** Patients who are systemically unwell

**How to access service:** Submit referral via Pleural Procedures Admission Avoidance service by selecting the blue send for triage button.

Internal referral from UHB only – PleuralReferralsUHB@UHBW.nhs.uk For enquiries please telephone 0117 3424101.

**The clinics are every Tuesday afternoon and Friday. We triage all referrals and book into the soonest clinic available. Priority will be given to those who need symptomatic relief to avoid admission and patients referred in the 2 week wait category. If you wish to discuss the referral please call 0117 3424101.**

* **Please ensure patient contact telephone number is included*.***
* **Please attach a copy of the patient’s recent medications and relevant medical history.**
* **If attending from ED, please ensure a copy of the ED notes are attached.**

**If referring patients for a procedure please ensure they are aware of this and that they may be in the department for some time**

**Pleural Procedures Admission Avoidance Clinic Referral Form**

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| **Patient details (In Block Capitals):** | **GP details:** |
| Name: | Name: |
| M/F: | Practice: |
| d.o.b: | Address: |
| NHS Number: |  |
| Hospital Number: |  |
| Address: |  |
|  |  |
| Postcode: | Postcode: |
| **Telephone No:** | **Name of referrer:** |
| Date and time of referral: | **Contact number/bleep of referrer:** |
| **Referral from: GP / 2WW / ED / Medical Take / Oncology / Other** | **Signature of referrer:** |

**Please answer the following questions to help us allocate appropriate time for procedures:**

Pleural Effusion: Y/N Significant SOB: Y/N 2WW Referral: Y/N

□Investigative Referral (Pleural disease to be investigated and followed up by Pleural Clinic)

□Therapeutic Referral (Results and follow up to be organised by referring team)

Is the patient taking: Warfarin Y/N DOAC Y/N Clexane Y/N Clopidogrel Y/N

Recent (within 4 weeks): INR Platelets

**Reason for referral:**

(Please include relevant PMH/DNAR status).

**Procedures Required**

Fluid required for analysis Y/N

□Protein, LDH

□MC+S

□Cytology

□AFB

Other (Please specify)

Therapeutic Aspiration Required Y/N

If **Yes** does the patient:

Have known diagnosis Y/N (please specify) Had previous failed pleurodesis Y/N

Had previous complications from pleural procedures Y/N (please specify)

Have any reason why procedure may be difficult Y/N (please specify)