COMMUNITY RESPIRATORY TEAM

HOME OXYGEN REFERRAL FORM

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| **Patient Details** | |
| Patient Name: | NHS Number: |
| Telephone number: | Date of Birth: |
| Address: | |

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| **GP Details** | |
| GP Name: | Practice Name: |
| Practice telephone number: | Email address |
| Practice address: | |

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| --- | --- | --- | --- |
| Diagnosis: | | | |
| Oxygen saturations: | At Rest: | Ambulatory: | Date recorded: |

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| Does the patient have a confirmed respiratory diagnosis? | YES | NO |
| Are the patients oxygen saturations 92% or below? | YES | NO |
| Is the patient in a stable condition (free from exacerbation for 8 weeks)? | YES | NO |
| Has the patient had spirometry performed in the last 12 months? | YES | NO |
| Verbal consent gained from patient for Oxygen referral? | YES | NO |
| **If the answer is “NO” to any of the above questions and you wish to speak to a member of the community respiratory team, please call 0117 9617159, alternatively re-refer when appropriate.** | | |
| **Does the patient smoke? If yes, Please explain it is very unlikely oxygen will be prescribed due to lack of clinical benefit and risks to self and others.** | YES | NO |

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| Additional Information……. |

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| **Patients preferred place for assessment** | | | | | |
| **SIRONA**  **Community Clinics** | YES | NO | **University Hospitals Bristol and Weston** | YES | NO |
| **North Bristol Trust (Southmead/Cossham)** | YES | NO | **Patients Home (Housebound ONLY)** | YES | NO |

|  |  |
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| Name of Referrer: | Date: |

PLEASE SEND COMPLETED REFERRAL TO [SIRONA.RESPIRATORY@NHS.NET](mailto:SIRONA.RESPIRATORY@NHS.NET)