NHS
North Yorkshire and York
Community and Mental Health Services

REFERRAL FORM FOR COMMUNITY RESPIRATORY NURSE

Patient Details: (Affix Patient Label)	**Name of Referring Practitioner:**
Name: _____	_____
NHS/Hospital No: _____	Telephone No: _____
Date of Birth: _____	Key worker: _____
Address: _____	Telephone No: _____
_____	Date of referral: _____
Telephone No: _____	Is the referral urgent Yes☐ No☐

Respiratory Diagnosis:

COPD ☐ (Mild ☐ Moderate ☐ Severe ☐)

Pulmonary Fibrosis ☐ Other: _____

Respiratory Medication:	**Please provide following information:**
Inhalers: _____	Attended pulmonary rehabilitation Yes☐ No☐
_____	Spirometry: Date: _____
_____	FEV, ___ L (___% Predicted)
Nebulisers: _____	FVC, ___ L (___% Predicted)
_____	FEV,/FVC _____%
Other: _____	Oxygen Saturations: _____%
_____	ABG (if available):
Oxygen: LTOT ☐ Short Burst ☐ Ambulatory☐	PO_2_____ PCO_2 _____ PH _____

Reason for referral:

☐ Symptom Management: _____

☐ Medication Review/Oxygen Requirements: _____

☐ Supportive and Palliative Care: _____

☐ Educational Needs: _____

☐ Other: _____

Does the patient require a Home Visit? ☐YES ☐NO

Could the patient attend a clinic appointment? ☐YES ☐NO

Request for a joint visit with the Key worker ☐YES ☐NO

	Tel	**Fax**	**email**
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For audit: Level of intervention required: 1 2 3 4 Date Received: _____ Date of visit: _____