**Referral for Home Oxygen Therapy Assessment**

Send: Respiratory Department, Salisbury NHS Foundation Trust, SP1 8BJ

Email: sft.respiratorynurses@nhs.net

**Patient Details:**

|  |  |  |  |
| --- | --- | --- | --- |
| Hospital no. |  | NHS no. |  |
| Surname |  | Forenames |  |
| Previous surname |  | Title |  | Gender |  |
| Date of birth |  |  |  |
| AddressPost Code |  | Home tel. no. |  |
| Work tel. no. |  |
| Mobile no. |  |

**Referral Details:**

|  |  |  |  |
| --- | --- | --- | --- |
| Referring clinician |  | Preferred clinician (if applicable) |  |
| GP Practice/ Department |  | New referral?  | [ ]  | Re-referral? | [ ]  |
| Date of referral |  | Date last seen |  |
| Date of consultation |  | Dates not available |  |

**Communication and Accessibility needs:**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Interpreter required? | Yes | [ ]  | No | [ ]  | Wheelchair access required?  | Yes | [ ]  | No | [ ]  |
| Language:  |  | Learning Disability:  |  |
| Hearing: |  | Other disability needing consideration:  |  |
| Vision: |  |

|  |  |
| --- | --- |
| Smoking Status  |  |
| Referral for Smoking Cessation |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| [ ]  | Military Service Person | [ ]  | Military Veteran | [ ]  | Member of Military Family |
| **Oxygen is a drug, attracts a daily tariff and is a treatment for hypoxia rather than breathlessness**. **(BTS 2015)** |
| * If the patient is not known to the Respiratory Consultants please consider referral
* Please check the patient’s oxygen saturations on air at rest ideally six weeks post any exacerbation
* Please check that the patient would accept 02 if it was appropriate.
* Please ensure that base line blood tests including Hb have been checked prior to referral
 |
| If the patient’s oxygen saturations are **≤ 93%** on air at rest please refer to the Respiratory Nursing Team for a Long Term Oxygen Therapy Assessment. | [ ]  |
| If the patient’s oxygen saturations are normal at rest **(≥ 94%)** but they desaturate on exertion please refer to the Respiratory Nursing Team for Ambulatory 02 assessment | [ ]  |

|  |
| --- |
| **Primary Care Management to date & any additional information**  |

|  |
| --- |
| PMHx :  |
| Medication (Please ensure that the patient’s oral or inhaled therapy is optimised) :  |
| Allergies :  |
| % Oxygen saturations on air at rest |  | Lowest %02 saturation on exertion |  |

All patient referrals must be made using this form.