**Referral for Home Oxygen Therapy Assessment**

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

Email: [sft.respiratorynurses@nhs.net](mailto:sft.respiratorynurses@nhs.net)

**Patient Details:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Hospital no. |  | NHS no. |  | | |
| Surname |  | Forenames |  | | |
| Previous surname |  | Title |  | Gender |  |
| Date of birth |  |  |  | | |
| Address  Post 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 | | | | | | |  |

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| --- |
| **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.