**UHS Home Ventilation Referral Form**

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| **PATIENT DETAILS** |
| Name:  Address:  DOB:  NHS number:  Contact number (landline and mobile if available):  GP details:  Outpatient/inpatient (including ward details): |
| **REFERRER DETAILS** |
| Responsible consultant:  Name and grade of referrer (if not consultant):  Specialty:  Referring trust:  Contact details including telephone number: |
| **REFERRAL DETAILS** |
| Date of referral:  Referral type: **URGENT** **ROUTINE**  Diagnosis: COPD OHVS OSA MND MS Cerebral palsy Spinal Injury  Kyphoscoliosis/Chest wall deformity DMD Myotonic dystrophy.  Other:  Indication for NIV (please highlight):   * 2 or more admissions with acute on chronic T2RF requiring NIV/mechanical ventilation with dates of admission * Symptomatic chronic T2RF (excessive daytime somnolence or morning headaches) * Suspected nocturnal hypoventilation (excessive daytime somnolence or morning headaches) in the absence of T2RF * Transfer of care of patient already set up on NIV (if so please provide ventilator settings/mode/make) * Other   Clinical details:  Relevant past medical history:  Current medication: |
| **TESTS** |
| Tests performed (please highlight):   * Overnight pulse oximetry/sleep study * Spirometry +/- gas transfer measurements * Sniff pressures * Arterial/capillary blood gas  |  |  |  |  | | --- | --- | --- | --- | |  | 1st Sample | 2nd Sample | 3rd Sample | | Date |  |  |  | | FiO2 |  |  |  | | NIV settings (if applicable) |  |  |  | | pH |  |  |  | | pO2 |  |  |  | | pCO2 |  |  |  | | Bicarbonate |  |  |  | | BE |  |  |  | | Lac |  |  |  |   *Please attach copies of test results with this referral* |
| **ESCALATION** |
| Has resuscitation been discussed with the patient? YES NO  If yes, has a DNACPR decision been agreed? YES NO  Appropriate ceiling of care? L3 L2 L1 |
| **CARE REQUIREMENTS** |
| * Independent * Family – if so, is overnight support available? * Carers – if so how many times per day and is overnight care available? * Residential/nursing home |
| **TRACHEOSTOMY PATIENTS** |
| *For tracheostomy ventilated patients only*  Date of tracheostomy:  Surgical tracheostomy / Percutaneous tracheostomy:  Tracheostomy size: Tracheostomy make:  Arrangements in place of tracheostomy changes: Relatives Care agency Hospital  If in hospital:  Responsible trust and consultant: |
| **INPATIENT REFERRAL** |
| *For inpatient referrals only*  Current NIV settings at local trust:  IPAP EPAP FiO2 Tidal volume (mls):  Ventilator make: Mode of ventilation:  *Patients will only be accepted for inpatient transfer to HDU on the proviso they are accepted back to referring trust once set up on a ventilator (if unable to be discharged home from UHS or ongoing care requirements)*  *It is the responsibility of the local clinical team to inform the NIV physiotherapists when patients are discharged from hospital on home ventilation so follow up can be arranged* |
| **SIGNATURE** |
| Signature: Date: |

*Please email this referral along with scanned copies of all relevant tests performed at local trust to* ***homeventilationservice@uhs.nhs.uk***

*To contact the NIV physiotherapy/nursing team please ring* ***023 8120 4416***

*To contact the NIV medical team please ring our secretary Debbie on* ***023 8120 6686***