REFERRAL FORM OXYGEN ASSESSMENT

PLEASE FAX to whichever trust you have selected:

Aintree	LHCH	RLBUHT
Oxygen assessment	Respiratory nurse	Oxygen Assessment
service	specialists	Service
Respiratory unit	Liverpool Heart and Chest	Cardio Respiratory Dept
Aintree Hospitals	Hospital	RLBUHT
Longmoor Lane	Thomas Lane	Prescot street
L9 7AL	L14 3PE	Liverpool L7 8XP
Fax	Fax	Fax
0151 529 2478	0151 600 1538	0151 706 5343
Tel queries:	Tel queries:	Tel queries:
0151 529 3852/8334	0151 600 1535/1537	0151 706 2852/2710

Patient name	GP name	
Gender: ♂ or ♀		
Patient address	GP address	
Postcode	GP telephone No.	
Patient Telephone number	GP fax No.	
Date of birth	Community Matron name	
NHS No.	Community Matron tel./mobile No.	
Next of Kin/ Carer & Contact Tel. No.	Is the patient known high risk or have any alerts?	

Cont. patient n	ame		Date of birth		
•	pecific diagnosis ite box(es) below		patient	nt may be receiving oxygen? Please	
COPD If yes, spirome	MRC try results (where			Is this patient suitable for pulmonary rehabilitation?	
FEV ₁	% predicted		FVC [% predicted	
Please tick:					
Chronic asthm	a			FEV ₁ /FVC%	
Interstitial lung	disease				
Bronchiectasis					
Pulmonary vas	cular disease				
Other – please	specify				
Long Term O2 Ambulatory O2 Short Burst O2	current HOOF if a TherapyL. Property Therapy	Hrs/day Hrs/day Hrs/day ge in the patier		nical status which has lead to this	
Smoking Statu	s:-		1		
Current	Ex smoker (appro	ox. how long quit)	Non s	smoker	
Secondary Pol	ycythaemia:-				
Yes	No	Unknown			
Clinical or echo	ocardiographic evi	idence of cor pu	ulmonal	ıle:-	
Yes	No	Unknown			
Current medication (or please attach list from your information system)					
	SP Signature:			Date :	