

## **NHS Foundation Trust**

## **Long Term/Ambulatory Oxygen Assessment Referral**

Name	
D.O.B	
Address	
Tel Number	
NHS Number	
GP and Practice	
Reason for Referral	LTOT AOT
Diagnosis	
Last CXR	Date:
Last Bloods	Date:
Last Spirometry	Date:
Spirometry Results	FEV1: %Pred: FVC: %Pred: Disease Severity:
MRC	
MRC	
MRC Currently on O2	Y/N
	Flow Rate: Duration: Cylinders/Concentrator
Currently on O2	Flow Rate: Duration:
Currently on O2  If yes  Any relevant/recent blood gas results or	Flow Rate: Duration: Cylinders/Concentrator pH: pCO2: PO2: HCO3: Base:
Currently on O2  If yes  Any relevant/recent blood gas results or oxygen saturations.  Current Mobility (including any walking aids)  PMH	Flow Rate: Duration: Cylinders/Concentrator pH: pCO2: PO2: HCO3: Base:
Currently on O2  If yes  Any relevant/recent blood gas results or oxygen saturations.  Current Mobility (including any walking aids)	Flow Rate: Duration: Cylinders/Concentrator pH: pCO2: PO2: HCO3: Base:
Currently on O2  If yes  Any relevant/recent blood gas results or oxygen saturations.  Current Mobility (including any walking aids)  PMH  Any other relevant	Flow Rate: Duration: Cylinders/Concentrator pH: pCO2: PO2: HCO3: Base:



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Referrer	
Job Title	
Contact Number	
Date of Referral	
Patient consent	
gained for this	
referral (will be	
rejected without)	

Note: Wherever possible the patient will need to be referred onto the oxygen team for initial assessment unless urgent i.e. Palliative. If urgent then please complete part A of the HOOF and then refer to oxygen team.

Please enclose a copy of this individual's current medication list.

Please note this referral is for a stable assessment. If urgent please ring to discuss.

Tel: 01928 753165 Fax: 01928 753888

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