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|  **North East Assisted Ventilation Service Referral Form**Please note fields are NOT mandatory**All requests for inpatient review at the referring hospital must be discussed by the referring Consultant with the on-duty Assisted Ventilation Consultant – 0191 (28)77589**North East Assisted Ventilation Service Home Ventilation Telephone: (0191) 282 3153 Level 5 New Victoria Wing On-duty Consultant Telephone: (0191) 2877589Royal Victoria Infirmary Referral Email: Nuth.home.ventilation@nhs.net Newcastle upon Tyne Consultant Email: Nuth.ventilation.consultants@nhs.net NE1 4LP  |
| **Patient Details:** (Please complete patient details) |
| Name: |  | NHS Number: |  |
| Address: |  | Hospital Number: |  |
| Postcode: |  | DOB: |  |
| Telephone Number: |  | Gender: |  |
| Patients Current Location: |  | Clinical Diagnosis: |  |
| GP Name: |  | GP Address: |  |
| **Clinical Details:** (Please include current treatment, settings, admission and current ABG) |
| Pre-NIV ABG: |  | Current ABG: |  | Current NIV Settings: |  |
| pH: |  | pH: |  | Mode: |  |
| pO2: |  | PC02: |  | IPAP: |  |
| PO2: |  | pO2: |  | EPAP: |  |
| HCO3: |  | HCO3: |  | Back up rate: |  |
| BE: |  | BE: |  | 02 requirement: |  |
| Current NIV dependency /usage |  |
| **Type of Assessment required:** (Please provide estimated discharge date if inpatient) |
| Inpatient assessment requested:(Discuss with duty NEAVS consultant) |  | Outpatient assessment requested: |  |
| **What is your question to the North East Assisted Ventilation Service?** |
| **Please provide a brief medical history including lung function, sleep studies and medication list (can be attached separately if required).** |
| **Social considerations/ independence with managing treatment/ family support/ potential care package requirement.** |
| **Referrer Details:** |
| Name and Profession: |  | Hospital: |  |
| Consultant: |  | Ward: |  |
| Direct Telephone No: |  | Email: |  |
| Signature: |  | Date: |  |