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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) 2877589 Royal Victoria Infirmary Referral Email: Nuth.home.ventilation@nhs.net  Newcastle upon Tyne Consultant Email: [Nuth.ventilation.consultants@nhs.net](mailto: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: | |  | | |