NHS
Midlands Partnership
NHS Foundation Trust
A Keele University Teaching Trust

MPFT Respiratory Service including Home Oxygen Service; Assessment and Review (HOS-AR)

Patient Name:		**NHS Number**	
Address:		**DoB:**	
		Tel:	
		Mobile:	
GP Name & Practice			
Respiratory Diagnosis*:			
Past Medical History* *(Please include a copy of GP summary from your clinical system if possible)*:			
Medications* *(Please include a copy from your clinical system if possible)*:			

Reason for referral:

☐ Acute Exacerbation ☐ General Management ☐ Respiratory Physiotherapy ☐ Pulmonary Rehabilitation ** ☐ Home Oxygen Service (PTO)

Supporting Information for Reason for Referral:

DENOTES MANDATORY REQUIREMENT FOR REFERRAL. PLEASE ALSO INCLUDE A COPY OF RECENT CHEST X RAY / CT THORAX AND SPIROMETRY REPORT. FAILURE TO ENCLOSE INFORMATION WILL RESULT IN YOUR REFERRAL BEING REJECTED.

****If referring for Pulmonary Rehabilitation, please ensure:**

1) **Diagnosed respiratory condition where breathlessness impacts on ADL or exercise capacity**
2) **Any known cardiac conditions must be well controlled and stable**
3) **The limitation to exercise must be due to shortness of breath, i.e. not neurological or musculoskeletal in nature**
4) **Recent MI (Within 12 weeks) should be referred for Cardiac Rehab**

Referring Clinician Details:

Name: Job Title:

Signature: Contact Number:

Date:

Once completed please email this form to:

South Staffordshire Referrals: mpft.respiratorysouth@mpft.nhs.uk
Cannock Chase Respiratory Service, Heath Hayes Health Centre, Gorsemoor Road, Heath Hayes, WS12 3TG
Stafford and Surrounds Respiratory Service, Weeping Cross Health Centre, Bodmin Avenue, Stafford, ST17 0EG

North Staffordshire/ Stoke on Trent referrals: mpft.longtermconditions@mpft.nhs.uk Stoke Health Centre, Honeywall, Stoke on Trent, ST4 7JB

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Home Oxygen Referrals: Pre-Referral Considerations

- Any other co-morbidity and referral for definitive diagnosis if not known
- Treatment optimisation
- Consider referral for smoking cessation
- Consider referral to palliative care and end of life planning conversation
- If patient is in hospital – plan discharge with HOS-AR service if oxygen to be considered at home.

Diagnosis

Clinical Diagnosis:

Current Smoker YES/NO (please circle) If Yes Number of Pack Years:

Relevant Medical History:

Haemoglobin result & date:

Pulse Oximetry: (On Air) (on L/min Oxygen)

- Patient has clinical signs of hypoxia (e.g. cor pulmonale, pulmonary hypertension, polycythaemia, cyanosis with SpO2≤ 92% during a period of stability of 5 weeks *(treatment has been optimised)* PLEASE INCLUDE LATEST ECHOCARDIOGRAM AND HB RESULT – Long Term Oxygen Therapy (LTOT) assessment required. ☐
- Active patient does not have oxygen and O2 saturation drops by >4% to below 90% on exertion - Ambulatory Oxygen Assessment required. ☐
- Patients who are currently on oxygen who require an ambulatory assessment ☐
- Palliative patients with an O2 saturation of < 92% - if more than 92% please contact the team to discuss ☐
- Terminal patients – **Please complete a Part A HOOF and inform the HOS-AR service** ☐
- Cluster Headaches (South only) – Please ensure patient has an accurate diagnosis from a neurologist. ☐

PLEASE ATTACH:-

- **A LIST OF CURRENT MEDICATIONS**
- **GP SUMMARY (IF PRIMARY CARE REFERRAL)**
- **HOSPITAL DISCHARGE LETTER OR CLINICAL LETTERS (IF HOSPITAL REFERRAL)**
- **CHEST X RAY REPORT**
- **RECENT SPIROMETRY REPORT (ALL RESPIRATORY PATIENTS)**

Capillary/ Arterial Blood Gas Results (obtained when clinically stable)		
Date of Measurement		
Oxygen Flow Rate		
PH		
PO2		
PCO2		
HCO3		
Base Excess		

Is this patient clinically stable? (free from exacerbations for at least 5 weeks) Yes/ No

If no, does the patient frequently exacerbate? Yes/No

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