Harefield Hospital referral for NIV Fax to :01895 828731/01895 828851

PLEASE SEND WITH AN OLD CLINIC LETTER GIVING DIAGNOSIS INCL ANY LUNG FUNCTION RESULTS AND OTHER MEDICAL CONDITIONS AND DRUG TREATMENTS

Name: DOB:

Address: Current location (incl ward):

Telephone number: Home Mobile:

Named consultant: Bleep no./mobile no. of SpR:

Estimated date of discharge: Follow-up arrangements:

Diagnosis:

Acute event precipitating acute-on-chronic type II respiratory failure and evidence (eg CXR changes, CRP)

On long-term oxygen therapy: Y/N Flow rate, device and hours/day:

Indication for NIV (any of following):

☐ 2 or more admissions with acute-on-chronic type II respiratory failure requiring NIV/mechanical ventilation. Dates of admission:

☐ Symptomatic chronic type II respiratory failure (excessive daytime somnolence or morning headaches)

☐ Suspected nocturnal hypoventilation (excessive daytime somnolence or morning headaches) in the absence of chronic type II respiratory failure

NIV settings required if had NIV previously: IPAP EPAP

Arterial blood gas on air/long-term oxygen therapy on admission:

	On admission	Most recent-please state time and date and if after night of NIV
FiO_2		
pH		
PaO_2		
$PaCO_2$		
HCO_3		
SaO_2		

Any discussion about intubation and CPR in event of future deterioration, if so with who and outcome of discussion?

Please note: we are unable to accept a referral that does not include a recent ABG ie within 48hrs of referral.