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**Harefield Hospital home oxygen assessment and review service**

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| **Patient details:** **Title:** Mr Ms Miss Mrs Other  **Surname:**  **Forename(s):**  **NHS Number:**  **Address:**  **Postcode: DOB:**  **Home: Mobile:**  **Date of last exacerbation** (treatment undertaken)  **Is the patient being discharged from hospital?** (include dates)  Discharge summary attached ☐  **Oxygen saturations** (on air at rest)  **Allergies:**  Yes:  No: ☐ Please specify: | **GP details:**  **Name:**  **Address:**  **Tel: Fax:**  **CCG:** |
| **Referrer details:**  **Name:**  **Position:**  **Email: @nhs.net**    **Address:**  **Tel: Fax:**  **I confirm the patient fulfils referral criteria:** Yes  No  **I confirm the patient is aware of the referral:** Yes  No  **Signed: Date:** |
| **Primary cardio-respiratory diagnosis:**  **Blood gases:** Date:On air/oxygen:  pH pO2  pCO2 HCO3 BE | **Oxygen history:**  **Is the patient receiving domiciliary oxygen therapy?**  Long term:  Ambulatory:  No oxygen therapy:  Please specify: |
| **Assessment requested:**  Long term oxygen therapy assessment  Ambulatory oxygen assessment  Other**:** | **Potential hazards:**  Infection risk  Falls history  BMI  Mobility concerns  Memory concerns  Other**:** |
| **Past medical history:** | **Medication list:** |
| **Considerations for referral:**  **Long-term oxygen therapy assessment**  Consider referring patients for a long term oxygen therapy assessment if they have:   * A respiratory or cardiac diagnosis with resting saturations of ≤92% * A respiratory or cardiac diagnosis AND presence of peripheral oedema, polycythaemia or pulmonary hypertension AND resting saturations of ≤94% * Been started on oxygen via a HOOF A prescription     **Ambulatory oxygen therapy assessment**  Consider referring patients for an ambulatory oxygen therapy assessment if they have:   * Long-term oxygen therapy and are active outdoors * Are being considered for an exercise programme such as pulmonary rehabilitation     **Cluster headaches:**  Consider referring for high flow short burst oxygen therapy as part of the management of cluster headaches  **Nocturnal oxygen therapy:**  Can be considered in patients with severe heart failure with nocturnal hypoxia in the absence of other causes of sleep disordered breathing or daytime hypoxia  *If you should need to refer a patient who does not meet this referral criteria, please*  *do not hesitate to contact a member of the home oxygen team on 01895 828851* | |
| **Please send / fax / email to:**  Home Oxygen Assessment and Review Service, Respiratory medicine  Harefield Hospital, Hill End Road, Middlesex, UB9 6JH  **Telephone:** 01895 828 851 **Fax**: 01895 828 889  **Email referrals:** [rbh-tr.oxygen@nhs.net](mailto:rbh-tr.oxygen@nhs.net) from an nhs.net account | |
| **Service administration only:**  Signed:  Date received:  Accepted:  On waiting list:  Rejected:  LTOT assessment:  ABOT assessment:  Other: | |