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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 medicineHarefield Hospital, Hill End Road, Middlesex, UB9 6JH**Telephone:** 01895 828 851 **Fax**: 01895 828 889**Email referrals:** 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:  |