**ALL BOXES MUST BE COMPLETED THEN EMAIL TO:**

**rbh-tr.svoutreachteam@nhs.net**

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| --- |
| **Referral Proforma: Long term respiratory care****SLEEP AND VENTILATION TEAM RBHT**(for Non-invasive review, Invasive ventilation support/weaning/ Tracheostomy support) |
| **Referral details** |
| **Referrers name:**  | **Date of referral:** |
| **Name of referring hospital / GP / service:** | **Ward (if hospital):**  |
| **Name of responsible consultant:**  | **Consultant Contact number (mobile):** Junior Doctors Bleep / Contact number: |
| **Reason for referral:** | **Patients location:**  |
| **Patient demographics** |
| **Patient Name:**  | **NHS number:**  |
| **Sex:**  | **D.O.B:**  |
| **Home address:** **Contact number:**  |
| **GP name:** **Surgery address:** **Phone number:** |
| **Carers/NOK Name:** **Relationship:** **Contact number:**  |
| **Clinical details** |
| **Primary Diagnosis (including recent events/HPC):** |
| **Past Medical History:** |
| **Resuscitation status / Ceiling of Care:** |
| **Current Condition/treatment to date:**

|  |  |  |
| --- | --- | --- |
| **TEST** | **DATE** | **OUTCOME** |
| **Covid-19 PCR** |  |  |
| **Covid-19 PCR** |  |  |
| **Covid-19 PCR** |  |  |

 |
| **Relevant investigations** **(CT/CXR/ECG/Sleep study/Spirometry):**  |
| **Latest ABG result:**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Date** | **Time** | **FiO2** | **On/off NIV** | **pH** | **PaCO2** | **PaO2** | **HCO3** | **BE** | **SaO2** |
|  |  |  |  |  |  |  |  |  |  |

**If Non-Invasive Ventilation - Current non-invasive ventilation settings:**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Mode** | **IPAP / PS** | **EPAP** | **BPM** | **Ti** | **Rise** | **FiO2** | **Target Tv (if iVAPS/AVAPS)** | **Hrs used last 24 Hrs** |
|  |  |  |  |  |  |  |  |  |

**If Tracheostomy Invasive Ventilation - Current invasive ventilation settings:**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Mode** | **PS** | **PEEP** | **BPM** | **FiO2** | **Avg RR** | **Avg VTE** |
|  |  |  |  |  |  |  |

**Tracheostomy tube make/model:** **Date of insertion:** **Cuff up/down:** |

|  |
| --- |
| **Outcome and Plan****(to be completed on review)** |
| **Outcome:** **Home ventilation settings**Device:SN:BC:DN:---------------------------------------Mode:BPM:EPAP:IPAP/PS:Ti:Rise:Trigger:Cycle:---------------------------------------**IVAPS/AVAPS**Pt Height:Target VA:Target TV:Vt/kg:---------------------------------------Mask:Size:Trache:Size:Humidifier:(include level of independence with NIV/TIV use, people trained, any tolerance/compliance issues)**Plan:** (include discharge destination, required follow up/training needs) |
| **CLINICIAN:** | **REVIEW DATE:** |