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

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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:** |