Referral Proforma for Management of Chronic Respiratory Failure at Royal Brompton Hospital

This information will facilitate transfer of the patient

Please complete fully and fax to: 020 7349 7764

<table>
<tr><td>Patient Name</td><td colspan="2"></td></tr>
<tr><td>DOB</td><td colspan="2"></td></tr>
<tr><td>Sex (delete appropriately)</td><td>Male</td><td>Female</td></tr>
<tr><td>Weight</td><td colspan="2">Kg</td></tr>
<tr><td>Home address

Contact number</td><td colspan="2"></td></tr>
<tr><td>GP details (including contact number)</td><td colspan="2"></td></tr>
<tr><td>Referring Hospital (full address)

Ward name
Ward contact number
Fax number</td><td colspan="2"></td></tr>
<tr><td>Date of referral</td><td colspan="2"></td></tr>
<tr><td>Referrers details
Name

Contact number

Responsible Consultant</td><td colspan="2"></td></tr>
<tr><td>Main Diagnosis/Reason for referral</td><td colspan="2"></td></tr>
<tr><td>Resuscitation Status</td><td colspan="2"></td></tr>
<tr><td colspan="3">Please delete as appropriate:</td></tr>
<tr><td>Level 1 or 2 bed?</td><td>Level 1</td><td>Level 2</td></tr>
<tr><td>Side Room?</td><td>Yes</td><td>No</td></tr>
<tr><td>PEG/NG fed</td><td>PEG</td><td>NGT</td></tr>
<tr><td>Tracheostomy in situ?</td><td>Yes</td><td>No</td></tr>
</table>

<table>
<tr><td rowspan="2">If Tracheostomy, please state Size and Type
(fenestrated/unfenestrated, cuff up/down, capped/speaking valve)</td><td colspan="2">Size:</td></tr>
<tr><td colspan="2">Type:</td></tr>
<tr><td colspan="3">NIV/CPAP Needs:</td></tr>
<tr><td rowspan="3">Please state IPAP/EPAP

Please state if using day/night (delete appropriately)
If using in day, please state how many hours.

PLEASE NOTE, THE PATIENT MUST BE ABLE TO BREATHE SPONTANEOUSLY FOR AT LEAST 20 MINUTES FOR SAFE TRANSFER</td><td colspan="2">IPAP: cmH2O
EPAP: cm H2O
FiO2: l/min
CPAP cmH2O</td></tr>
<tr><td>Day + Night</td><td>Night only</td></tr>
<tr><td>Day time hours of use: Hours</td><td></td></tr>
<tr><td>Most recent blood gas (please include FiO2/whether on or off NIV)</td><td colspan="2">pH:
pCO2:
pO2:
HCO3:
FiO2: l/min On/Off NIV? :</td></tr>
<tr><td>Relevant medical history</td><td colspan="2"></td></tr>
<tr><td>Current medications

Allergies</td><td colspan="2"></td></tr>
<tr><td>Infection Status: Please state MRSA status (SWABS MUST BE SENT PRIOR TO TRANSFER) and any other infection control needs (eg C diff/Acinetobacter)
Please fax copy of MRSA screen to:</td><td colspan="2"></td></tr>
<tr><td>Current nursing needs/mobility
Please liaise with nursing and physiotherapy staff before completing this section and provide as much detail as possible</td><td colspan="2"></td></tr>
<tr><td>Discharge plan:
Is patient expected to return to referring hospital after treatment at Royal Brompton Hospital before final discharge?</td><td colspan="2"></td></tr>
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To be completed by RBH Staff	
Priority	
Estimated length of stay	
Accepting Consultant	
Planned investigations (TOSCA/NIV set-up, etc)	