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| **North East Assisted Ventilation Service Motor Neurone Disease referral form**Please note fields are not mandatoryWe will assume this is a referral for outpatient assessment unless there is a clinical discussion with one of the NEAVS consultant team on 0191 (28)23153, option 1. North East Assisted Ventilation Service Home Ventilation Telephone: (0191) 282 3153 Level 5 New Victoria Wing On-duty Consultant Telephone: (0191) 2877589Royal Victoria Infirmary Referral Email: Nuth.home.ventilation@nhs.net Newcastle upon Tyne Consultant Email: Nuth.ventilation.consultants@nhs.net NE1 4LP  |
| **Patient Details:** (Please complete patient details) |
| Name: |  | NHS Number: |  |
| Address: |  | Hospital Number: |  |
| Postcode: |  | DOB: |  |
| Telephone Number: |  | Gender: |  |
| Patients Current Location: |  | Clinical Diagnosis: |  |
| GP Name: |  | GP Address: |  |
| **Reason for Referral:** (Please complete reason for referral) |
| Hypercapnia on ARTERIAL blood gas (please add full result below) |[ ]  Heavy snoring |[ ]  Poor cough/ secretion retention |[ ]
| Daytime somnolence |[ ]  Bedfellow has noted nocturnal apnoeas |[ ]  Recurrent/ non-resolving respiratory infections |[ ]
| Poor sleep quality/ Awakes unrefreshed |[ ]  Signs/ evidence  of right heart failure |[ ]  Orthopnoea |[ ]
| Headaches on waking |[ ]  Abnormal overnight oximetry (please attach study to referral) |[ ]  Raised venous bicarbonate (Caveats: renal failure and diuretics) |[ ]
| Sialorrhoea |[ ]  No symptoms; baseline assessment only |[ ]   |[ ]
| **Type of Assessment required (see note above):** Please provide estimated discharge date if inpatient |
| **What is your question to the North East Assisted Ventilation Service?****Can this patient be considered for NIV?** **Can this patient be considered for cough assist?** **Other & Supporting details:** |
| **Please provide a brief medical history including any overnight oximetry / TCC02, arterial blood gases or lung function that are available.** |
| **Social considerations/ independence with managing treatment/ family support/ potential care package requirement.** |
| **Referrer Details:** |
| Name and Profession: |  | Consultant: |  |
| Direct Telephone No: |  | Hospital: |  |
| Email: |  | Ward: |  |
| Signature: |  | Date: |  |