|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **North East Assisted Ventilation Service Motor Neurone Disease referral form**  Please note fields are not mandatory  We 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) 2877589 Royal Victoria Infirmary Referral Email: Nuth.home.ventilation@nhs.net  Newcastle upon Tyne Consultant Email: [Nuth.ventilation.consultants@nhs.net](mailto: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: | | |  | |