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| **North East Assisted Ventilation Service 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 Royal 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: |  |
| **Clinical Details:** (Please include current treatment, settings, admission and current ABG) |
| Pre-NIV ABG: |  | Current ABG: |  | Current NIV Settings: |  |
| pH: |  | pH: |  | Mode: |  |
| PCO2: |  | PC02: |  | IPAP: |  |
| PO2: |  | PO2: |  | EPAP: |  |
| HCO3: |  | HCO3: |  | Back up rate: |  |
| BE: |  | BE: |  | 02 requirement: |  |
| Current NIV dependency /usage |  |
| **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 e.g High flow nasal oxygenOther request & Supporting details: |
| **Please provide a brief medical history including lung function, sleep studies and medication list (can be attached separately if required).** |
| **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: |  |