|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **North East Assisted Ventilation Service 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 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: | |  | |
| **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 oxygen  Other 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: | |  | |