

**SHROPSHIRE RESPIRATORY SERVICE REFERRAL FORM**

**Please ensure you adhere to the referral criteria for each service or the referral may be returned to you. See separate referral form for Pulmonary Rehabilitation.**

**We will require an up to date EMIS and a copy of the most recent spirometry with each referral.**

**Patient Details**

**Name:**

**NHS No:**

**DOB**

**Address:**

**Date of referral:**

**COPD Service criteria: Confirmed diagnosis of COPD, 2 or more COPD exacerbations within 12 months, 1 hospital admission due to COPD or worsening symptoms despite maximal therapy.**

**Oxygen Assessment clinic criteria: Must have a diagnosis to explain the hypoxia. SpO2 below 92% on 2 separate occasions, at least 4 weeks apart when clinically stable and fully optimised, or 94% if there is evidence of peripheral oedema, polycythaemia or pulmonary hypertension. Oxygen assessment for Cluster headaches will only be accepted with a neurologist’s recommendation.**

**Additional Information:** please give as much detail as possible of what you would like us to achieve from the appointment, include any relevant history, medication, blood results, x-ray results, scan results etc……….

**Referred Name, position and contact details:**

**Which Service would you like to refer to?**

**COPD Nurse Led Service**

**Home visit (housebound patients only)**

**Clinic**

**Clinic locations: Shrewsbury, Ludlow, Bridgnorth, Oswestry, Whitchurch**

**Oxygen Assessment Service**

**URGENCY**

**Urgent**

**Routine**

**Risk to lone worker? Yes  NO**

**If yes give detail below**