**REFERRAL PROFORMA FOR HOME MECHANICAL VENTILATION and VENTILATOR WEANING SUPPORT**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **ALL BOXES MUST BE COMPLETED.**  **EMAIL TO: rbh-tr.svoutreachteam@nhs.net** | | | | | | | | | | | | | | | | | | | | | |
| **REFERRER DETAILS** | | | | | | | | | | | | | | | | | | | | | |
| **Name of referring hospital / service** | | | | | | | | | | | **Date of referral** | | | | | | | | | | |
|  | | | | | | | | | | |  | | | | | | | | | | |
| **Referring consultant name and contact details (mobile phone and email)** | | | | | | | | | | | **Patients current location:** | | | | | | | | | | |
|  | | | | | | | | | | |  | | | | | | | | | | |
| **PATIENT DEMOGRAPHIPCS** | | | | | | | | | | | | | | | | | | | | | |
| **Patient Name** | | | |  | | | | | | | **NHS number** | | | | | | |  | | | |
| **Gender** | | | |  | | | | | | | **D.O.B** | | | | | | |  | | | |
| **Home address** | | | |  | | | | | | | | | | | | | | | | | |
| **Contact number** | | | |  | | | | | | | | | | | | | | | | | |
| **GP name and address** | | | |  | | | | | | | | | | | | | | | | | |
| **GP phone number** | | | |  | | | | | | | | | | | | | | | | | |
| **Carers/NOK Name & relationship** | | | | | | | |  | | | | | | | | | | | | | |
| **Contact number** | | | |  | | | | | | | | | | | | | | | | | |
| **CLINICAL DETAILS** | | | | | | | | | | | | | | | | | | | | | |
| **Reason for referral** | Initiation of home NIV (inpatient set up) | | | | | | | | |  | | Transfer of care / review of existing NIV | | | | | | | | |  |
| Long term home tracheostomy ventilation | | | | | | | | |  | | Complex respiratory assessment inc. cough | | | | | | | | |  |
| Inpatient tracheostomy / ventilation weaning support | | | | | | | | |  | | Outpatient sleep and ventilation referral  *Please send via NHS e-referrals or a direct letter to a Sleep & Ventilation Consultant unless specific Outreach input required* | | | | | | | | |  |
| **Is the patient / NoK aware of this referral and accepting of treatment?** | | | | | | | | | | | | | | | | | | | Yes / No | | |
| **Current medical condition and primary diagnosis** | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |
| **COVID-19 PCR** | | | **Date** | | | |  | | | | | | **Outcome** | | |  | | | | | |
| **Date** | | | |  | | | | | | **Outcome** | | |  | | | | | |
| **Relevant past medical history** | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |
| **Height** | |  | | | | **Weight** | | | |  | | | | | **BMI** | | | | |  | |
| **Resuscitation status / Ceiling of Care** | | | | | | | | |  | | | | | | | | | | | | |
| **Treatment to date**  *Please include NIV usage and tolerance, weaning episodes and tolerance, oxygen usage* | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |
| **Relevant investigations** **(CT/CXR/ECG/sleep studies/spirometry/etc)** | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |
| **Latest ABG results** | | | | | | | | | | | | | | | | | | | | | |
| **Date** | | | |  | | | | | | **Date** | | | | | | |  | | | | |
| **Additional O2/RA** | | | |  | | | | | | **Additional O2/RA** | | | | | | |  | | | | |
| **ON ventilation** | | | |  | | | | | | **OFF ventilation** | | | | | | |  | | | | |
| **pH** | | | |  | | | | | | **pH** | | | | | | |  | | | | |
| **pCO2** | | | |  | | | | | | **pCO2** | | | | | | |  | | | | |
| **pO2** | | | |  | | | | | | **pO2** | | | | | | |  | | | | |
| **HCO3** | | | |  | | | | | | **HCO3** | | | | | | |  | | | | |
| **BE** | | | |  | | | | | | **BE** | | | | | | |  | | | | |
| **Sats** | | | |  | | | | | | **Sats** | | | | | | |  | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |
| **Current ventilation (complete as appropriate)** | | | | | | | | | | | | | | | | | | | | | |
| **Non-Invasive Ventilation** | | | | | | | | | | **Invasive Ventilation** | | | | | | | | | | | |
| **Mode** | | | |  | | | | | | **Mode** | | | | | | |  | | | | |
| **IPAP / PS** | | | |  | | | | | | **PS / PC / Volume set** | | | | | | |  | | | | |
| **EPAP** | | | |  | | | | | | **PEEP** | | | | | | |  | | | | |
| **BPM** | | | |  | | | | | | **RR set** | | | | | | |  | | | | |
| **Ti** | | | |  | | | | | | **FiO2** | | | | | | |  | | | | |
| **Rise** | | | |  | | | | | | **Trigger** | | | | | | |  | | | | |
| **Oxygen** | | | |  | | | | | |  | | | | | | |  | | | | |
| **Target Vt (IVAPS / AVAPS)** | | | |  | | | | | |  | | | | | | |  | | | | |
| **Hours used in last 24 hours** | | | |  | | | | | |  | | | | | | |  | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |
| **Tracheostomy (if appropriate)** | | | | | | | | | | | | | | | | | | | | | |
| **Tracheostomy make / model** | | | | |  | | | | | | | | | **Size** | | |  | | | | |
| **Date of insertion** | | | | |  | | | | | | | | | **Cuff status** | | |  | | | | |
| **Weaning to date** | | | | |  | | | | | | | | | | | | | | | | |