|  |  |
| --- | --- |
| Referring GP: |  |
| Practice Name: |  |
| Practice Address: |  |
| Telephone: |  |
| Fax: |  |
| Ref: |  |

Request Type:Advice/Referral Date of Referral:

Specialty:

Dear Colleague

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Patient Surname: |  | | Patient Title: | |  | | Date of Birth: | | | |  |
| Forename(s): |  | | | Gender: | |  | | Ethnicity: | |  | |
| Address (inc postcode): | | | | **NHS Number:** | | | **UBRN** | | | | |
|  | |  | | | | | | | | | |
| Preferred Tel No: | |  | | | | | | | | | |
| Tel No (Home): | |  | | | Tel No (Mobile): | | | |  | | |
| Patient’s email: | |  | | | | | | | | | |

|  |  |
| --- | --- |
| **Patient Information:** *Please answer the questions below:* | |
| Does your patient have needs that you feel might be able to be accommodated with reasonable adjustments to normal outpatient clinic arrangements? i.e. downstairs, wide door access, no lifts |  |
| Does your patient have a cognitive impairment e.g. learning disability, dementia? |  |
| Does your patient have a sensory impairment? |  |
| Does your patient have a physical impairment? |  |
| Name of Carer/Family Member/Friend (if applicable) |  |
| Is an interpreter required? If yes please state language |  |

**Primary Reason for Referral:** *(Please be as specific as possible: are you looking for clarificaiton of causality, are there any expectatons of onward referral?)*

**Referral Letter:** *(Include any advice or management plans, or attach physio/ESP referral letter)*

**Relevant Past Medical History:** *If none please state*

**Current Medication:** *If none please state*

**Allergies:** *Medication or other adverse effects – If none please state*

|  |  |
| --- | --- |
| **Referral Metrics:** (Please include latest results where available) | |
| **Body Mass Index (BMI)** |  |
| **Blood Pressure** |  |
| **Smoking Status** |  |
| **Pulse** |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Consider:** (*Please include latest results where available)* | | | | | |
|  | **Date** | **Result** | | | |
| **CXR** |  |  | | | |
| **Resting SaO2** |  |  |  |  |  |
|  |  | **SaO2 after one minute activity** | **PR after one minute** | **SaO2 at 2mins**  **(1 min recovery)** | **PR at 2mins** |
| **One minute sit stand test (or alternative desaturation test)** |  |  |  |  |  |

|  |  |  |
| --- | --- | --- |
| **Test** | **Date** | **Result** |
| FBC Visc/CRP |  |  |
| HbA1c |  |  |
| U&E |  |  |
| LFT |  |  |
| TFT |  |  |
| If SOB- BNP Consider troponin / echo |  |  |
| If significant myalgia - Creatine Kinase |  |  |
| If fatigued: Chronic fatigue screen (Add coeliac screen calcium) |  |  |
| Urinalysis |  |  |
| ECG |  |  |
| Covid Test or Covid antibody serology |  | Please note the patient does not need a positive test for referral to this clinic. This is optional to complete. |

Yours faithfully