Please complete the below information in full and send via email to:

[RightCareBarnsleyIntegratedSPA@swyt.nhs.uk](mailto:RightCareBarnsleyIntegratedSPA@swyt.nhs.uk)

For queries or urgent advice / support. Telephone: 01226 644575

If using SystmOne and e-referral can be sent to the Breathe Service via the Neighbourhood Teams SystmOne Unit.

**Urgency:**

Urgent (Within 24 hrs)  Routine (Within 72 hrs)  Planned (Within 7days)  Other (Over 7 days)

**Urgent referrals are for patients at risk of deterioration and those who are experiencing an exacerbation which is normally stable.**

**For crisis referrals, where a patient is at risk of hospital admission, is deteriorating or is unable to manage at home post hospital discharge please contact the Single Point of Access on 01226 644575 with relevant clinical information.**

**Service required:**

Respiratory Consultant Clinic Specialist Respiratory Nurse Clinic

Specialist Respiratory Nurse Home visit  Specialist Respiratory Physiotherapist

Specialist Respiratory Occupational Therapist

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| --- | --- | --- |
| **Patient Name** | **NHS number** | **Date of Birth** |
| **Address** | **Telephone Number** | **Mobile Number** |
| **Next of Kin Name** | **Next of Kin Relationship** | **Next of Kin Contact Details** |
| **Referrer Name** | **Designation** | **Contact Details** |

|  |  |
| --- | --- |
| **Referrals MUST include the following information.**   * Does the patient have a confirmed diagnosis of respiratory condition?   Yes  No  Please provide further details:   * **Respiratory History:** Please include nature and duration of symptoms, date of diagnosis where applicable, MRC Dyspnoea Scale (Level of function); peak flow record (best peak flow), history of atopy, quality of life information, relevant occupational and exposure history. * **Past Medical History:** Please include all other conditions. * **Medication:** Please include all repeat medication and allergy information. * **Recent and relevant investigations:** E.g. chest x-ray (taken within the timescale of current symptoms / past 3 months), recent blood investigations (including FBC, U&E), sputum culture (any antibiotics prescribed). * **Spirometry and other lung function:** Please include date and findings and attach copy of trace. (minimum required information FEV1/FVC ratio FEV1% predicted and FVC) * **Exacerbation:** Please include if the patient is currently being treated for an exacerbation and number of exacerbations in last 12m and number of respiratory hospital admissions in the last 12m if known. Please attach list of exacerbation treatment. | |
| **Oxygen**   * Oxygen saturation on air. * Oxygen saturation on LTOT and flow rate of oxygen. |  |
| **Current Symptoms**  **Breathlessness at rest  Breathlessness on exertion  Cough  Wheeze**  **Chest Tightness  Oedema  Chest Pain  Purulent Sputum** | |
| **What is the main problem you would like help with and reason for referral to the BREATHE Service?** | |