Lothian Long Term Ventilation Service

Patient Referral Form

Please complete the form in CAPITALS and fax to 01315371 or 01315371 or email LTV@nhslothian.scot.nhs.uk

This is supplemental information to the standard referral letter and only include if information absent form referral letter

Name of Patient	**NHS Number**	**DOB/Age/Gender**		
Date of Referral	**Name of referring hospital**	**Name of ward and contact details**		
Name and grade of individual completing form				
Name of referring consultant				
Name of Social Work contact / team if appropriate				
Date of admission to hospital	☐			
Date of intubation/initiation of NIV (delete as appropriate)				
Primary medical diagnosis				
Major complications	**1.**			
	2.			
	3.			
Co-morbidities	**1.**			
	2.			
	3.			
Date of tracheostomy (if appropriate)	**-----/-----/2014**			
Latest ABG	**pH**	**PO2 (kPa)**	**PCO2 (kPa)**	**HCO3- (mmols/l)**
Latest Ventilator Setting	**FiO2 (%) L/min O_2**	**PSV (cmH2O)**	**CPAP (cmH2O)**	**Mode PSV/PCV/CPAP**
How is the patient fed?	**Oral/NG/PEG/JEJ**			
Is patient awake, alert and orientated during the day?	**Yes** ☐			
Is the patient confused?	**Yes (Day & Night)** ☐	**Yes (Night only)** ☐	**Occasional** ☐	**Never** ☐
Is the patient mobile?	**Independent** ☐	**Assistance for transfer** ☐	**Sitting Out** ☐	**Fully Dependant** ☐
Ensure the patient and their relatives are issues with a Lothian LTV Service patient information leaflet				