The Respiratory Unit: Request Form

St John & St Elizabeth Hospital

☐ Outpatient ☐ Daycase ☐ Inpatient

Hospital Number:

Surname:

Forenames:

DOB:.

☐ Male ☐ Female

Address:

Postcode:

Tel / Mobile:

☐ Self Paying ☐ Insured ☐ Third Party

☐ Walking ☐ Wheelchair ☐ Bed / Trolley ☐ Hoist

Investigation(s) requested

Please see guidance notes for referrers overleaf

☐ Spirometry / Flow Volume Loop

☐ Reversibility Test (Drug Prescription below)

☐ Full Lung Function (Spirometry/Volumes/Diffusion)

☐ SpO2 (Pulse Oximetry)

☐ Referral to Sleep Unit

☐ Diagnostic Sleep Study

☐ Sleep Study, and where appropriate CPAP set up**

☐ Allergy Skin Prick Test (Airborne allergens only)

☐ Fractional Exhaled Nitric Oxide (FeNo)

Investigation(s) requested by Specialist Respiratory / Cardiology Consultants only

☐ CPAP Set-up

☐ Cardiopulmonary Exercise Test (CPEX)*

☐ Mannitol Challenge (Bronchial Challenge)

☐ Hypoxic Inhalation Challenge (Oxygen Assessment for Air Travel)

☐ Arterial Blood Gas

☐ Overnight SpO2 Study

☐ Ambulatory Oxygen Assessment

☐ Long Term Oxygen Assessment (Maximum of 3L/min, unless specified by referring clinician)

☐ Sleep Study on CPAP

☐ Six Minute Walk Test

For the use in Home Sleep Study

** If the diagnosis is positive for OSA, I agree for the named patient to be referred to a Respiratory Consultant in the Sleep Unit at the Hospital of St John & St Elizabeth for immediate treatment with CPAP, as recommended by the sleep specialist report.

Current Medication:

Any known infection(s)

☐ Tuberculosis ☐ MRSA ☐ Pneumonia ☐ HIV

Clinical Information and Reason for Test:

☐ Beta-Blocker ☐ Antihistamine

Prescription for use in Respiratory Lung Function Reversibility test only:

PATIENT DRUG PRESCRIPTON FORM ON ABOVE NAMED PATIENT ONLY:

Salbutamol Inhaler ☐ 200 micrograms ☐ 400 micrograms

**Signature of Referring Clinician:

(please read the Referrer's disclaimer overleaf)

Date of Request:

Email for Results:

Name of Referring Clinician:

Tel:

Mobile:

SS. John and Elizabeth Charity, Registered Charity No: 235822 Version 1 SP3141-01/2022 Review Date: January 2025

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*Relative Contraindications to Cardiopulmonary Exercise

- ☐ Aortic Stenosis / Murmur
- ☐ LBBB/AF on ECG
- ☐ Resting Chest Pain
- ☐ History of Ventricular Arrhythmias
- ☐ HOCM
- ☐ Angina <1/12 post MI / PCI / CABG
- ☐ Problems with mobility (Will patient be able to pedal on the bike? E.g. arthritis of hip / knee)

Guidance Notes for Referrers

- Respiratory Investigations will only be performed upon written request signed by a registered medical or dental practitioner or by an authorised non-medical practitioner.
- Referrals (request form or letter) must precede or accompany the patient. Faxes are accepted.
- All requests must carry sufficient information to identify the patient, normally consisting of the first name, middle initial (if any), family name, date of birth and address.
- All requests must carry sufficient clinical information to enable the requested examination to be justified in line with national and local guidelines.
- All requests shall clearly state the examination requested.
- All requests must include the contact details of the referring clinician including address, telephone and fax numbers.

**Referrer's Declaration

By signing the request form you are confirming the following:

- **The correct details have been provided**
- **You have discussed the examination including any intervention**
- **You have taken into account the possibility of pregnancy**
- **There are no known contra-indications to performing the requested examination**
- **You will ensure the examination results are recorded in the patient's records**

Consent for Spiro, Full Lung Function, Sleep Study, O2 assessments, CPAP

The patient has been provided with the consent information sheet(s) for the procedure(s) Yes ☐ No ☐

The patient has given verbal informed consent to the procedure(s) Yes ☐ No ☐

Name of operator: _____ Signed: _____ Date: _____

For Cardiac Unit Use Only:

Affix Patient Label

Request Form Check

- ☐ Three Points of ID Checked
- ☐ Previous testing Checked
- ☐ Examination Checked with Patient
- ☐ Protocol Confirmed
- ☐ Pregnancy Status Documented

Consent for CPEX, Skin Prick Test, Reversibility, 6MWT

The patient has been provided with the consent information sheet(s) for the procedure(s) Yes ☐ No ☐

Statement of the patient/person with parental responsibility for patient:

I have read all of the information provided and all of my questions / concerns have been answered. I agree to the procedure(s).

Signed (patient): _____ Date: _____

Name (print): _____

Consent for Arterial Blood Gases

You must use Hospital Consent Form 3 or 4. Please refer to the Hospital Consent Policy for further guidance.