Welbeck

WELBECK LUNG HEALTH PROCEDURE REQUEST

Please complete all sections of the form. **By completing this form, you confirm you have the consent required to share this information.**

PATIENT DETAILS

Title:	Forename:	Surname:
MRN:		
Date of birth:		Gender: ☐ Male ☐ Female ☐ Other
Residential address:		Postcode:
Telephone:	Mobile:	Email:

PROCEDURE & ENDOSCOPIST DETAILS

Referrer name:	Endoscopist:
Referrer address:	
Reason for referral:	
Procedures(s):	
☐ E5180 – Diagnostic bronchoscopy +/- biopsy	Indication and clinical details for examination:
☐ E6310 – Endobronchial ultrasound-guided transbronchial needle aspiration (EBUB-TBNA) for mediastinal masses2	
☐ E5100 – Endobronchial ultrasound (as sole procedure)	☐ Pleural Drain:
Sedation: ☐ Yes ☐ No	
Date & time of procedure (if known):	Estimated procedure duration:

GP (OR OTHER REFERRER) DETAILS

Gp/referrer name:	Gp/referrer practice:
Gp/referrer contact number:	Gp/referrer email:

DRUG & MEDICAL HISTORY (TICK YES IF RELEVANT)

Pacemaker/Defibrillator/loop recorder	☐ Yes	☐ No	Is the patient diabetic:	☐ Yes	☐ No
Aneurysm clips	☐ Yes	☐ No	Known renal impairment	☐ Yes	☐ No
Cochlear Implants	☐ Yes	☐ No	Preferred radiologist:	☐ Yes	☐ No
Anticoagulant/Antiplatelet	☐ Yes	☐ No	Rheumatoid arthritis	☐ Yes	☐ No
Aspirin	☐ Yes	☐ No	Cardiac vascular pacemaker	☐ Yes	☐ No
Diabetes – Insulin / Tablet	☐ Yes	☐ No	Respiratory	☐ Yes	☐ No
Allergies (please list in other)	☐ Yes	☐ No	Ability to consent	☐ Yes	☐ No
Infective (E.G. HIV / TB / Hepatitis)	☐ Yes	☐ No	Mobility problems (please specify)	☐ Yes	☐ No
CJD Risk	☐ Yes	☐ No	Other (please state):		

PAYMENT DETAILS

TYPE: ☐ Self-funding ☐ Insured ☐ Embassy ☐ Other (please complete below sections as appropriate)		
Insurance company:	Membership no.	Authorisation code:
Embassy:	Letter of guarantee: ☐ Yes (please attach)	

Please attach the last clinic letter, any relevant test results and any additional documentation to this form & submit to us via one of the following:

T: +44 (0)203 653 2005
E: bookings.bronchoscopy@onewelbeck.com

A: Welbeck Heart Health & Lung Health
1 Welbeck Street, London W1G 0AR

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EXTRA REQUIRMENTS

Special equipment requirements:	Wheelchair access: ☐ Yes
Interpreter required: ☐ Yes, please confirm language:	
Other:	Dietary requirements:

DECLARATION & FORM SUBMISSION

☐ I authorise this patient to undergo the above order.

Name:	Signed:	Date:

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