Welbeck

Welbeck Lung Health Diagnostic Test Referral Form

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:

REFERRAL DETAILS

OneWelbeck Lung Health Diagnostic test(s):

☐ **Spirometry**
Reporting doctor:

☐ **Full Lung Function Test**
(Spirometry, Diffusion, Lung Volumes)
Reporting doctor:

☐ **Spirometry + Reversibility**
Reporting doctor: 2.5mg Salbutamol

☐ **Full Lung Function Test + Reversibility**
Reporting doctor: 2.5mg Salbutamol

☐ **Exhaled Nitric Oxide *(FeNO)***
Reporting doctor:

☐ **Bronchial Provocation Test**
Reporting doctor: Mannitol / Methacholine

☐ **Nebulised drug trial**
Reporting doctor:
Specify drug:

☐ **Cardio-Pulmonary Exercise Test**
Reporting doctor:

☐ **VO_2 Max**
Reporting doctor:

☐ **Pleural Drain**
Reporting doctor:

☐ **Sputum induction**

☐ **Respiratory Muscle Strength**
(Positional SVC + MIP/MEP)
Reporting doctor:

☐ **1 Minute Sit-To-Stand**
Reporting doctor:

☐ **Capillary Blood Gases**
Reporting doctor:

☐ **TOSCA Sleep Study *(CO_2 monitoring)***
Reporting doctor:

☐ **NoxT3 Sleep Study**
Reporting doctor:

☐ **Sleep Image**
Reporting doctor:

☐ **Sunrise Device**
Reporting doctor:

☐ **Fitness to Fly**
Reporting doctor:

☐ **Peak Expiratory Flow Monitoring**
Reporting doctor:

☐ **Skin Prick testing**
☐ 1-10 ☐ 11-20

☐ **Exercise Induced Bronchial Provocation**
Reporting doctor:

☐ **CPAP - new patient set-up** ☐ **CPAP - treatment review** ☐ **BIPAP**

☐ **Follow up consultation on completion of tests (Welbeck only)**

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.hearthealth@onewelbeck.com

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

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PATHOLOGY

☐ **Blood Tests (please specify profile):**	**Microbiology:**
	☐ Sputum Culture & Sensitivities ☐ Sputum TB Culture & Sensitivities ☐ Sputum TB Detection by PCR ☐ Sputum Legionella Antigen ☐ Sputum AFB Culture & Microscopy ☐ Sputum Fungal Culture ☐ Sputum Cell Differential ☐ Sputum PCR Viral Test

(Induction may be required to obtain sufficient sample*)

CLINICAL INDICATION & ADDITIONAL INFORMATION

Please complete any clinical indications or additional information

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)	

EXTRA REQUIRMENTS

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

DECLARATION & FORM SUBMISSION

☐ I authorise this patient to undergo the above order.

Name:	Signed:	Date:

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