OneWelbeck 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(S): SURNAME:

DATE OF BIRTH: GENDER: ☐ MALE ☐ FEMALE ☐ OTHER

RESIDENTIAL ADDRESS: POSTCODE:

TELEPHONE: MOBILE:

EMAIL:

REFERRAL DETAIL

OneWelbeck Lung Health Diagnostic test(s):

☐ **Spirometry**
☐ **Spirometry + Reversibility**
2.5mg Salbutamol
☐ **Full Lung Function Test**
(*Spirometry, Diffusion, Lung Volumes*)
☐ **Full Lung Function Test + Reversibility**
2.5mg Salbutamol
☐ **Exhaled Nitric Oxide (FeNO)**
☐ **Bronchial Provocation Test:**
Drug and dose Please select:
☐ **Exercise Bronchial Provocation Test:**
2.5mg Salbutamol
☐ **Nebulised drug trial**
Specify drug:
☐ **Physiotherapy referral**

☐ **Cardio-Pulmonary Exercise Test**
☐ **Respiratory Muscle Strength (Positional Spirometry+MIP/MEP)**
☐ **Capillary Blood Gases**
☐ **1-minute sit-to-stand**
☐ **NoxT3 Sleep Study**
☐ **Sunrise Sleep Study**
☐ **Fitness to Fly**
☐ **Peak Expiratory Flow Monitoring**
☐ **CPAP** - new patient set-up
☐ **CPAP** - treatment review
☐ **Sputum Induction**
Hypertonic Saline 3-7%

☐ Follow-up consultation on completion of tests (OneWelbeck only)

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

☐ Cough
☐ Shortness of Breath
☐ Disease Progression

☐ Disease Monitoring
☐ Pre-Operative Assessment
☐ Other (Please Specify)

Other:

EXTRA REQUIREMENTS

SPECIAL EQUIPMENT REQUIREMENTS: WHEELCHAIR ACCESS:

INTERPRETER REQUIRED: ☐ YES- SPECIFY:

OTHER:

REFERRER DETAILS

GP/REFERRER NAME : GP/REFERRER PRACTICE :

GP/REFERRER CONTACT NUMBER: GP/REFERRER EMAIL:

PAYMENT DETAILS (IF KNOWN)

☐ Bill to Patient	☐ Bill to Insurer INSURANCE COMPANY: MEMBERSHIP NO: AUTHORISATION CODE:	☐ Bill to Embassy EMBASSY: LETTER OF GUARANTEE: ☐ (Please attach)	☐ Bill to referrer AGENCY NAME:

NAME : SIGNED : DATE :

PROFESSIONAL REG NO:

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

E: bookings.diagnostics@onewelbeck.com **A:** OneWelbeck Imaging & Diagnostics, 1 Welbeck Street, London W1G 0AR **T:** +44 (0)20 3653 2001