OneWelbeck Lung Health

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**
Reporting doctor: No preference

☐ **Spirometry + Reversibility**
Reporting doctor: No preference 2.5mg Salbutamol

☐ **Full Lung Function Test (*Spirometry, Diffusion, Lung Volumes*)**
Reporting doctor: No preference

☐ **Full Lung Function Test + Reversibility**
Reporting doctor: No preference 2.5mg Salbutamol

☐ **Exhaled Nitric Oxide (FeNO)**
Reporting doctor: No preference

☐ **Bronchial Provocation Test**
Reporting doctor: No preference Histamine

☐ **Nebulised drug trial**
Reporting doctor: No preference

Specify drug

☐ **Physiotherapy refferal** No preference

☐ **Cardio-Pulmonary Exercise Test**
Reporting doctor: No preference

☐ **Respiratory Muscle Strength (Positional Spirometry + MIP/MEP)**
Reporting doctor: No preference

☐ **1 Minute Sit-To-Stand**
Reporting doctor: No preference

☐ **Capillary Blood Gases**
Reporting doctor: No preference

☐ **NoxT3 Sleep Study**
Reporting doctor: No preference

☐ **Fitness to Fly**
Reporting doctor: No preference

☐ **Peak Expiratory Flow Monitoring**
Reporting doctor: No preference

☐ **CPAP - new patient set-up**

☐ **CPAP - treatment review**

☐ **Sputum induction**

☐ **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)

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 REQUIREMENTS

SPECIAL EQUIPMENT REQUIREMENTS: WHEELCHAIR ACCESS: ☐

INTERPRETER REQUIRED: ☐ Yes, please confirm language:

OTHER:

DECLARATION & FORM SUBMISSION

I authorise this patient to undergo the above order.

NAME: SIGNED: DATE:

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:
E: bookings.lunghealth@onewelbeck.com A: Bookings, OneWelbeck Lung Health, 1 Welbeck Street London W1G 0AR T: +44 (0)203 653 2005