

# 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: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other:	
RESIDENTIAL ADDRESS:		POSTCODE:
TELEPHONE:	MOBILE:	
EMAIL:		

## REFERRAL DETAIL

<b>OneWelbeck Lung Health Diagnostic test(s):</b> <input type="checkbox"/> <b>Spirometry</b> Reporting doctor: Requesting doctor  <input type="checkbox"/> <b>Spirometry + Reversibility</b> Reporting doctor: Requesting doctor      Drug Selection  <input type="checkbox"/> <b>Full Lung Function Test (Spirometry, Diffusion, Lung Volumes)</b> Reporting doctor: No Preference  <input type="checkbox"/> <b>Full Lung Function Test + Reversibility</b> Reporting doctor: Requesting doctor      Drug Selection  <input type="checkbox"/> <b>Exhaled Nitric Oxide (FeNO)</b> Reporting doctor: Requesting doctor  <input type="checkbox"/> <b>Bronchial Provocation Test</b> Reporting doctor: No Preference      Histamine  <input type="checkbox"/> <b>Nebulised drug trial</b> Reporting doctor: No Preference  Specify drug  <input type="checkbox"/> <b>Physiotherapy referral</b>	<input type="checkbox"/> <b>Cardio-Pulmonary Exercise Test</b> Reporting doctor: requesting doctor  <input type="checkbox"/> <b>Respiratory Muscle Strength (Positional Spirometry + MIP/MEP)</b> Reporting doctor: requesting doctor  <input type="checkbox"/> <b>1 Minute Sit-To-Stand</b> Reporting doctor: requesting doctor  <input type="checkbox"/> <b>Capillary Blood Gases</b> Reporting doctor: requesting doctor  <input type="checkbox"/> <b>NoxT3 Sleep Study</b> Reporting doctor: requesting doctor  <input type="checkbox"/> <b>Fitness to Fly</b> Reporting doctor: requesting doctor  <input type="checkbox"/> <b>Peak Expiratory Flow Monitoring</b> Reporting doctor: requesting doctor  <input type="checkbox"/> <b>CPAP - new patient set-up</b> <input type="checkbox"/> <b>CPAP - treatment review</b> <input type="checkbox"/> <b>Sputum induction</b> <input type="checkbox"/> <b>Follow-up consultation on completion of tests (OneWelbeck only)</b>
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## PATHOLOGY

<input type="checkbox"/> <b>Blood Tests (please specify profile):</b>	<b>Microbiology:</b> <input type="checkbox"/> Sputum Culture & Sensitivities <input type="checkbox"/> Sputum AFB Culture & Microscopy <input type="checkbox"/> Sputum TB Culture & Sensitivities <input type="checkbox"/> Sputum Fungal Culture <input type="checkbox"/> Sputum TB Detection by PCR <input type="checkbox"/> Sputum Cell Differential <input type="checkbox"/> Sputum Legionella Antigen <input type="checkbox"/> Sputum PCR Viral Test (Induction may be required to obtain sufficient sample*)
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## CLINICAL INDICATION & ADDITIONAL INFORMATION

Cough  
 Shortness of Breath  
 Disease Progression  
 Disease Monitoring  
 Pre-Operative Assessment  
 Other (Please Specify)

## PAYMENT DETAILS

TYPE: Self-funding <input type="checkbox"/> Insured <input type="checkbox"/> Embassy <input type="checkbox"/> Other (please complete below sections as appropriate)		
INSURANCE COMPANY:	MEMBERSHIP NO:	AUTHORISATION CODE:
EMBASSY:	LETTER OF GUARANTEE: <input type="checkbox"/> Yes (please attach)	

## EXTRA REQUIREMENTS

SPECIAL EQUIPMENT REQUIREMENTS:	WHEELCHAIR ACCESS: <input type="checkbox"/>
INTERPRETER REQUIRED: <input type="checkbox"/> Yes, please confirm language:	
OTHER:	

## DECLARATION & FORM SUBMISSION

I authorise this patient to undergo the above order.

NAME:	SIGNED:	DATE:
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**Peak Expiratory Flow Monitoring**  
Reporting doctor: requesting doctor

**CPAP - new patient set-up**

**CPAP - treatment review**

**Sputum induction**

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