

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

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

PATHOLOGY

<input type="checkbox"/> Blood Tests (please specify profile):	Microbiology: <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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