CRIS – Respiratory Referral Forms

Single Point of Referral – 0208 274 7088

Patient's Name:	
NHS Number:	**DOB:**
Address:	**Patient's Contact Number:**
Referrer's Name & Contact Number:	

Respiratory Diagnosis:

☐ Asthma ☐ Bronchiectasis ☐ Pulmonary fibrosis

☐ COPD ☐ Other _____

Current Symptoms:

☐ Dyspnoea – breathlessness ☐ Cough ☐ Sputum - Phlegm

☐ Wheeze ☐ Chest Tightness/Chest Pain

☐ Other-_____

Significant Medical Conditions:

☐ Motor Neurone Disorder (MND) ☐ Multiple Sclerosis (MS)

☐ CVA – Stroke (Cerebro Vascular Accident) ☐ Obesity

☐ Cardiac Conditions ☐ Dementia

☐ Anxiety & Depression ☐ Other-_____

Oxygen Therapy: Does the patient have long term oxygen therapy? ☐ Yes ☐ No

Are there any previous respiratory related admissions in the last 12 months? ☐ Yes ☐ No

Number of exacerbations in the last 12 months:_____

Were antibiotics required: ☐ Yes ☐ No

Were steroids required: ☐ Yes ☐ No

Does the patient require same day visit? : ☐ Yes ☐ No

Are there any problems gaining access to the property? ☐ Yes ☐ No

Is there a Key Safe Number?_____

Any communication/behavioural issues?

Any other ongoing medical problems we need to be aware of?