

Preferred language:

Interpreter required? Yes No

Current In-patient: Yes No **Hospital admitted at:** ... **Age:**

Overview referral

Clinical disease course: include details on prior treatments for lung disease, approximate start and stop dates, response, rate of decline, life threatening exacerbations etc.

Previous Ventilation: NIV Mechanical Ventilation

Urgency: High Urgency Transplant Currently Indicated Early Referral (Not yet indicated)

Respiratory History

Primary Diagnosis date: ...

Non-Respiratory

1. ...
2. ...
3. ...

Smoking status

Current smoker Yes No

If Yes, please refer to local cessation clinic & not
(Please note TSANZ guidelines regarding smoking cessation)

Ex-smoker Yes No

If Yes, Date ceased date: ...

Pack Year History date: ...

Cotinine Level _____ Date completed: _____

(Mandatory – within last 4 weeks)

Never smoked Yes No

Lung Function (Please attach lung function from the past 2 years)

FEV1 =	L	% Pred	TLC =	L	% Pred	
FVC =	L	% Pred	RV =	L	% Pred	
DLCO Adj Hb =		mL/min/mmHg	%Pred	KCO =	ml/min/mmHg/L	%Pred

Microbiology

Please attach the **last 12 months** of sputum results:

Results attached Yes No

Have the following organisms ever been isolated?

Burkholderia cepacia Yes No Date: ...

Pan-resistant Pseudomonas Yes No Date: ...

Scedosporium Yes No Date: ...

Mycobacteria (TB or NTM) Yes No Date: ...

Aspergillus Yes No Date: ...

Prev. Haemoptysis Yes No

Details: ...

Prev. Pneumothorax: Yes No

Details: ...

Prev. Thoracic Surgery: Yes No

Details: ...

Type of Pleurodesis:

Medical History Please complete all sections

Current or previous :

Details:

Stroke Yes No ...

Heart Disease Yes No ...

Renal Disease Yes No ...

If Yes, Last Creatinine: ... Date ... Last Urea: ...Date: ...

Liver Disease Yes No ...

Diabetes Yes No

If Yes, T1DM T2DM On Insulin Yes No Recent HbA1c:

GI Disease Yes No ...

Any Other relevant History Yes No

Details ...

Clinical Assessment (Please complete all sections)

Weight ...kgs Height ...m BMI* ...

If BMI > 35 not appropriate for referral. If BMI <18 please refer to local Dietitian.

Cyanosed Yes No Respiratory rate ... (bpm at rest)

Lymphadenopathy Yes No Oxygen Saturation ...% on AIR

Clubbed Yes No Blood pressure ...mmHg

Heart rate ...bpm regular irregular paced

Oxygen at home Yes No

If Yes; Requirements ...Litres at rest ...Litres on exertion

Method ... (Np/Hudson mask etc)

Current Exercise Capacity (Objective assessment)

Formal 6 minute walk test

Max distance ... metres Lowest saturation ...%

Performed on air / oxygen - If Oxygen ... litres per minute

Requires Wheelchair Yes No

Currently performing Pulmonary Rehab Yes No Dates and Details:

If No, please refer to local Pulmonary Rehab Program for initial assessment

Allergies:

Current Medication (list or attach print out)

Drug name	Strength	Dose / frequency / special

Family and Social History (Please complete all sections)

Family support available: Nominated primary support person

Known to Social Worker: Yes No

If Yes, Name: ... Contact details: ...

Accommodation (please circle): **Own** **Rented** **Staying with relatives**

Alcohol Yes No ... Unit per week

Previous heavy alcohol intake Yes No

Previous Illicit Drug use Yes No type

Any significant Family History:

...

...

Psychological assessment Current or Previous History of:

Depression: Yes No

Panic attacks: Yes No

Anxiety neurosis: Yes No

Other Psychiatric conditions: Yes No

(If Yes, comment): ...

...

Known to Psychiatrist Yes No

If Yes, Name: ... Contact details: ...

Required Investigation / Test Results:

Please ensure the following results are attached and detailed below.

**** To be completed: <12Months of referral**

ECG** Date performed: ...
Result: ...

Echocardiogram** Date performed: ...
Result: ...

Chest x-ray** Last performed: ...
Result: ...

Lung Function (Please attach lung function from the past 2 years)

HRCT Thorax: Date performed: ...

– Films/CD must accompany patient to first visit clinic

Result: ...
...

Arterial Blood Gas ON AIR – (Or state otherwise) Date performed: ...

pH: ... PO2: : ... PCO2: : ... BE: : ... HCO3: : ... SaO2: : ...

Others (only if available)

Bone Densitometry Date performed: ... Spine T score = ... Femur T score= ...

Right heart catheter Date performed: ...

Coronary Angiogram Date performed: ...

Any Other Comments Investigations / Test Results: (detail below or attach)

Signature of Referring Practitioner _____ **Date** _____