**Lane Fox Respiratory Service**

**Cough Assist Device Referral Form**

All referral forms to be sent gst-tr.lfureferrals@nhs.net with standard clinical referral letter following the advice on:

<https://www.guysandstthomas.nhs.uk/our-services/lane-fox/referrals.aspx>

All referrals should include an overnight respiratory study and up to date arterial blood gas result

***IMPORTANT: Lane Fox Respiratory Service is commissioned to provide cough assist devices for patients with chronic respiratory failure. The evidence for this device is limited and this is an agreement we have agreed with the CCG commissioners. In essence, a patient on the Lane Fox home mechanical ventilation programme will be eligible for a cough assists device if they have a neuromuscular condition reducing cough function. In particular, the cough assist device is for neuromuscular patients with chronic respiratory failure and/or nocturnal hypoventilation who have a peak cough flow less than 270L/min and either (1) 2 admissions to hospitals with chest sepsis requiring extended use of NIV or (2) 1 life-threatening admission to ICU with chest sepsis requiring intubation and invasive ventilatio*n**

**If you would like to discuss your case prior to formal referral then you can contact the clinical specialist physiotherapist on 07776492945 or** **emily.ballard@gstt.nhs.uk**

|  |  |  |
| --- | --- | --- |
| **Name of patient:** | **NHS no:** | **DOB/Age/Gender:** |

**Is this patient an inpatient: Yes □ No □**

**Anticipated discharge date if applicable:**

**Primary diagnoses**

|  |  |
| --- | --- |
| 1 |  |
| 2 |  |
| 3 |  |
| 4 |  |
| 5 |  |

**Number of chest infections in the last 12 months requiring a course of antibiotics without admission to hospital**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **None** |  | **< 2** |  | **≥2** |  |

**Number of chest infections in the last 12months requiring a course of antibiotics with admission to hospital**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **None** |  | **<2** |  | **≥2** |  |

**Invasive ventilation requirement: Yes □ No □**

**Non-invasive ventilation requirement: Yes □ No □**

**Is the patient on home non-invasive ventilation?**

Yes □

No □

**Most recent arterial blood gas result**

|  |  |
| --- | --- |
| **Date** |  |
| **Oxygen**  |  | L/min |
| **pH** |  |  |
| **PaO2** |  | kPa |
| **PaCO2** |  | kPa |
| **HCO3-** |  | mmol/L |

**Spirometry**

|  |  |
| --- | --- |
| **Date** |  |
| **FEV1** |  | L |
| **FVC** |  | L |
| **PCF** |  | L |

|  |  |
| --- | --- |
| **Name of referrer:** |  |
| **Name of consultant:** |  |
| **Hospital:** |  |
| **Contact number/bleep:** |  |
| **Date of Referral:** |  |