BTS Quality Standards for Home Oxygen Use in Adults

Appendix 4
Example assessment referral form from BTS Home Oxygen Guideline (2015)

HOME OXYGEN ASSESSMENT REFERRAL FORM

NHS no: Name: Address: Post code: Date of birth:	Tel No: Key contact (if different from patient): Name: Relationship: Tel No:	
GP name & address:		
Consultant name & address (if applicable):		
Primary diagnosis:		
Relevant secondary diagnoses:		
Oxygen saturation (on air at rest): Date taken: Blood gases: pH PO2 PCO2 (on air on oxygen please circle) if available		
Date of last exacerbation (treatment completed): Is patient being discharged from hospital?		
Smoking status (tick):	Never ☐ Ex ☐ , how long stopped …….. Current ☐	
Other potential hazards (tick any that may apply):	Lives alone ☐	Mobility issues (trips/falls) ☐
	Open fires ☐	Poor memory ☐
	Other ☐ (list)	
Allergies:	No ☐ Yes ☐ list any:	
Does the patient currently have any home oxygen? No ☐ Yes ☐ Details		
Is the patient or key contact aware of this referral? No ☐ Yes ☐		
Additional relevant information:		
Print Name:	Profession:	
Signature:	Date:	