FNH365775

Northern Health

BRONCHOSCOPY REFERRAL

AFFIX PATIENT IDENTIFICATION LABEL HERE

U.R. NUMBER: _____

SURNAME: _____

GIVEN NAME: _____

DATE OF BIRTH: _____/_____/_____ SEX: _____

❑ 3 points of ID checked

Patient Details: (*Minimum requirement to action referral)

Name*:_____

UR*: _____ DOB*:_____

Address: _____

_____

Sex: ☐ Male ☐ Female

Phone*:

Interpreter required? ☐ No ☐ Yes If yes specify language

_____

Smoker: ☐ No ☐ Yes If yes pack per year:

_____

Procedure requested*

Date of referral: _____

☐ Linear EBUS ☐ Bronchoscopy

☐ Radial EBUS ☐ Other (please specify):

_____

Referrer Details:

Requesting clinician*: _____

Consultant*: _____

Contact*: _____

Email*: _____

External provider number: _____

Follow up: ☐ NH ☐ Other please specify:

_____

Imaging:

☐ CT Date: _____ Location: _____

☐ PET Date: _____ Location: _____

Images transferred: ☐ Yes ☐ No

Infection Risk:

TB risk: ☐ High ☐ Low ☐ Nil

Other considerations: _____

Clinical Details*

Allergies / Adverse Drug Reactions:

Anaesthetic Risk:

☐ COPD
☐ Ischaemic heart disease
☐ Heart Failure
☐ Diabetes
☐ Asplenia
☐ Asthma
☐ Pulmonary hypertension
☐ Mechanical valve
☐ Endocarditis

Echo Results:

_____

Bloods: Hb: _____ Plts: _____ INR: _____ Date: _____

Lung Function: FEV1: _____ TLCO: _____ Date: _____

Medication:

☐ Aspirin ☐ Clopidogrel ☐ Insulin
☐ DOAC ☐ Warfarin ☐ Other antiplatelet - If other specify: _____
☐ Diabetes medication

Other considerations: _____

_____

Office Use:

Triage
- ☐ Cat 1
- ☐ Cat 2
- ☐ Cat 3

☐ Radiology
☐ Bloods

☐ Lung Function
☐ Echo
☐ NOA
☐ PAC
☐ Infection control
☐ Booking confirmed
☐ Equipment
☐ Results
☐ Follow - up

Please email referrals to bronchoscopy@nh.org.au Phone: 0436 672 060

Name:_____ Signature: _____

Designation: _____ Date: ___/___/___ Time: ___:___

HEALTH NORTHERN

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