Community Intervention Service Home Oxygen Referral form

Once complete please return this form to:
Email suffolk.ccc@esneft.nhs.uk

The service only accepts referrals for LTOT* and AO* for adults	
Referral criteria. Please confirm all areas have been met: ☐ **Pulse-oxymetry < 92% on air** ☐ **Patients condition is optimally controlled** ☐ **Patients condition has been stable for >5 weeks**	**Main diagnosis**
Patient Name **NHS No.** **Home Address** **Postcode** **Tel No** **D.O.B** **Sex M ☐ F ☐** **Is a visit required at the patients home? Yes ☐ No ☐**	**Referrer Details** **Name of referrer & Position:** **Date & Time of referral:** **GP:** **GP Address:** **Telephone Contact:**
Current medication (Up to date print out may be attached) Has the patient had a chest infection in the last 6 weeks?	
Home oxygen therapy history **Current oxygen user? Yes ☐ No ☐** **If yes what is the modality and current prescription:** **LTOT** L/min hrs **AO** L/min hrs **SBOT** L/min hrs **Last SpO2 reading** **On air/oxygen** (please delete) **Date:**	