BTS Quality Standards for Home Oxygen Use in Adults

Appendix 3
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: