

**Step 1:** This referral form is used to refer & register a new patient to the VRSS

**Step 2:** Please also attach a formal referral letter from referring doctor with patient clinical information/test results

**Step 3:** Email to [vrssadmin@austin.org.au](mailto:vrssadmin@austin.org.au)

## VRSS Referral Form

<b>Patient Details</b>			
Name:		Address:	
DOB:			
Austin UR (if known)		Phone No.:	
Medicare No. & Exp.:		Email:	
<b>MTDM or Contact Person/s Details (please provide minimum of 1)</b>			
(1) Name		(2) Name	
Relationship to pt		Relationship to pt	
Phone No.		Phone No.	

<b>Referring Doctor Name</b>			
Doctor Phone No. or Email			
Referring Institution			
Is the patient currently an IP?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Unit/Ward	
GP Name			
GP Clinic			

### Primary Diagnosis

**Restrictive Chest Wall Disease:**

- Kyphoscoliosis    Thoracoplasty  
 Other: \_\_\_\_\_

**Chronic Respiratory Disease:**

- COPD             Cystic Fibrosis  
 Bronchiectasis  
 Other: \_\_\_\_\_

Is this a bridge to transplant?    Yes  No

**Obesity Hypoventilation Syndrome**

**Neuromuscular Disease:**

- Motor Neurone Disease  
 Duchenne Muscular Dystrophy  
 Spinal Cord Injury  
 Myotonic Dystrophy  
 Spinal Muscular Atrophy  
 Cerebral Palsy  
 Other: \_\_\_\_\_

**Other Diagnosis:** \_\_\_\_\_

**Arterial Blood Gases** (venous blood gases are not acceptable)   Date: \_\_\_\_\_   FiO<sub>2</sub>: \_\_\_\_\_

pH \_\_\_\_\_   PaCO<sub>2</sub> \_\_\_\_\_   PaO<sub>2</sub> \_\_\_\_\_   HCO<sub>3</sub> \_\_\_\_\_   BE \_\_\_\_\_   SaO<sub>2</sub> \_\_\_\_\_

**Respiratory Function Tests** (please attach a copy)

Date		FEV <sub>1</sub>		FEV <sub>1</sub> % predicted	
		FVC		FVC % predicted	
		VC		VC % predicted	
		FEV <sub>1</sub> / FVC			