VRSS Referral Form

Date:________________

Patient Name		DOB	
UR Number		Phone No	
Address			

Community Contact Person			
Contact person Phone Number			
Referring Doctor			
Referring Institution			
Is the patient currently an IP?	Yes / No	Unit/Ward:	

1. Primary Diagnosis

Restrictive chest wall disease:

☐ Kyphoscoliosis

☐ Thoracoplasty

☐ Other: ______________________

Neuromuscular Disease:

☐ Post Polio Syndrome

☐ Spinal Cord Injury

☐ Duchenne Muscular Dystrophy

☐ Motor Neurone Disease

☐ Myotonic dystrophy

☐ Spinal Muscular Atrophy

☐ Other: ________________________

Obstructive Lung Disease:

☐ COPD

☐ Cystic Fibrosis

☐ Bronchiolitis Obliterans

☐ Other: ________________________

☐ **Obesity Hypoventilation Syndrome**

☐ **Other:** ________________________

Is this a bridge to transplant?: Yes / No

2. Arterial Blood Gases (please be aware that venous blood gases are not acceptable)

Date: ___________________ FiO_2: ________________

pH _______ $PaCO_2$ _______ PaO_2 _______ HCO_3 _______ BE _______ SaO_2 _____

3. Respiratory Function Tests (please include attached copy)

Date		FEV_1		FEV_1 % predicted	
		FVC		FVC % predicted	
		VC		VC % predicted	
		FEV_1 / FVC			

Step 1: Complete VRSS Referral Form to register / refer patient to the VRSS
Step 2: If referring from an External Institution, please also attach a letter from the referring Physician
Step 3: Fax to 9496 5768 marked “Attention: Carly Longo”, or return with clinic paperwork if Internal referral