

FAB Course Referral Form

**Please note a referral to the FAB course does not constitute a referral to St Peter’s Hospice CNS Team.**

**Please ensure all sections on both sides of the form are completed.**

**SECTION 1: PATIENT DETAILS**

|  |  |  |  |
| --- | --- | --- | --- |
| First Name |  | Surname |  |
| DOB |  | NHS No. |  |
| Contact Number |  | EMIS No. (optional) |  |

**SECTION 2: NEXT OF KIN**

|  |  |  |  |
| --- | --- | --- | --- |
| First Name |  | Surname |  |
| Relationship to the Patient |  |

**SECTION 3: MEDICAL INFORMATION**

|  |  |
| --- | --- |
| Primary Diagnosis |  |
| Relevant Past Medical History / Co-Morbidities |  |
| Medication |  |
| RESPECT / TEP Form | Yes No  |
| Allergies |  |

**SECTION 4: MOBILITY**

|  |  |
| --- | --- |
| How does the patient mobilise? | Independently With Assistance  |
| Use of mobility aids? | Stick Zimmer Frame Wheeled Walker Wheelchair  |

**SECTION 5: OXYGEN**

|  |  |
| --- | --- |
| Does the patient use oxygen? | Yes No  |
| If Yes: Long Term Oxygen Therapy (LTOT) Ambulatory Oxygen Therapy (AOT) |  l/min Duration (hours) l/min Duration (hours) |
| Which Respiratory team manage the Oxygen?  | Sirona UHBW NBT |

**SECTION 6: CONSENT**

|  |  |
| --- | --- |
| Please confirm the patient is aware of the referral and has consented. | Yes  |

**SECTION 7: REFERRER DETAILS**

|  |  |  |  |
| --- | --- | --- | --- |
| Referred By: |  | Designation: |  |
| Contact number: |  | Email address: |  |
| Signed: |  | Date: |  |

**St Peter’s Hospice**

**Charlton Road, Brentry, Bristol. BS10 6NL**

**Therapy Team Telephone Number 0117 915 9469**

**Once completed, please email to: referrals.administrator@nhs.net**