

**Bronchoscopy and Endobronchial Ultrasound Referral**

**(For Category 2 & 3 patients ONLY)**

Patient’s Name:       NHI:

DOB:       Address:

Mobile Phone (mandatory):       E-Mail (if available):

Referring Consultant:

E-Mail Address of the contact person from the Referring DHB:

Date of Referral:

A) Procedure Requested (*please tick*):

[ ]  Bronchoscopy

[ ]  Endobronchial Ultrasound (EBUS)

[ ]  Other Interventional Bronchoscopy, *please specify*

B) Reason for Referral (*please tick*):

[ ]  Diagnosis or staging of suspected cancer

[ ]  Mediastinal adenopathy ?cause

[ ]  Suspected TB

[ ]  Pulmo infiltrates for immune compromised

[ ]  ILD

[ ]  Others, *please specify*

C) Category 1, 2, & 3 (please tick):

[ ]  1 - Within **72 hours (ACUTE)**

This form is **NOT** applicable. Please use the **ACUTE** endoscopy form on WDHB intranet/internet.

[ ]  2 - Within **2 weeks** (e.g. HSCAN, TB)

[ ]  3 - Within **4 weeks** (e.g. Sarcoid, ILD, etc.)

D) Date and location of recent CT, PET/CT (Radiology of patients from other DHB **MUST** be sent electronically to Waikato PACS before submitting this request):

E) Clinical Details: (including presenting complaint, smoking history, relevant past history and ECOG functional status):

F) Is the patient currently on any anticoagulants / antiplatelet agents?

 [ ]  No [ ]  Yes; *please specify*:

G) Is the patient a diabetic?

 [ ]  No [ ]  Yes; *please specify medications if any*:

*An updated versions of* ***‘Management of Patients on Anticoagulants/Antiplatelets Undergoing Endoscopic Procedures’*** *and* ***‘Management of Diabetic Patients Undergoing Endoscopic Procedures’*** *are available on WDHB intranet and internet (under Respiratory Service). The vetting respiratory consultant will be responsible for withholding instruction/order of these medications. The bronchoscopy RN will then communicate these instructions to the patient at least 2 business days from withholding date.*

H) Blood results:

Date       INR       Hb       Platelets       Creatinine       eGFR

I) Lung function results:

Date       FEV1      L      % pred FVC      L      % pred DLCO            % pred

J) Has the patient agreed to the procedure?

[ ]  Yes [ ]  No

K) Any other comments:

* Please remind the patient not to smoke for at least 12 hours prior to the procedure
* Please note the referring DHB is responsible for organising transport and accommodation for the patient.
* Please e-mail: BronchEBUSReferral@waikatodhb.health.nz the completed referral form, with other relevant information.

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **FOR VETTERS ONLY** [ ]  Accepted [ ]  Declined, *please specify reason*      Bronchoscopy/EBUS List [ ]  Tuesday PM (Bronchoscopy/EBUS/Radial) – Room 4 (No TB Cases)[ ]  Wednesday PM (Bronchoscopy)[ ]  Thursday AM (Bronchoscopy/EBUS)[ ]  Friday PM (Bronchoscopy)Date of procedure:      Duration Procedure (1 unit = 20 mins)[ ]  Bronchoscopy (2 units) [ ]  EBUS (3 units)[ ]  Radial EBUS Guide Sheath with fluoroscopy (4 units)[ ]  EBUS + Bronchoscopy (4 units)[ ]  EBUS + Radial (5 units)Investigations Requested (*please tick*):

|  |  |
| --- | --- |
| [ ]  Bronchial washings  | [ ]  Bronchial brushings |
| [ ]  Transbronchial lung biopsy  | [ ]  Endobronchial lung biopsy |
| [ ]  BAL–cell count differential  | [ ]  CD4:CD8 Ratio (e.g. Sarcoid) |
| [ ]  Neutropenic sepsis protocol  | [ ]  Flow Cytometry (eg Lymphoma) |
| [ ]  EBUS/TBNA  | [ ]  Others, *please specify*       |

Location of Specimen:     [ ]  **Anticoagulation/Antiplatelet medications**  [ ]  Withhold as per WDHB guidelines  [ ]  Specific instructions:      [ ]   **Diabetes medications (oral hypoglycaemics and/or insulin)** [ ]  Withhold as per WDHB guidelines  [ ]  Specific instructions:      [ ]  TB precaution required (**LAST** case of the list)Other Comments:      Name of Vetting SMO:      Date:       |