# ILD Referral Proforma For: Clinic MDT Regional MDT 2nd Tues or 4th Mon

|  |  |
| --- | --- |
| **Question for MDT:** | |
| **Is this a *progressive fibrosis*ILD referral? : Yes / No (if so we need 24 months of historic lung function if available)** | |
| History & Exam  Findings: | Performance Status or Frailty Score: Sats: FiO2 : |
| Is there FHx of pulmonary fibrosis?: |  |
| Smoking or vaping history: |  |
| Co-Morbidities: |  |
| Drug History: |  |
| Previous ILD Rx: (specify dose & duration) |  |
| Occupation: |  |
| Connective Tissue Disease confirmed/suspected | Y / N, Details: |
| Exposures:  (Occupational and environmental) |  |

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Date** |  | |  | |  | |  | |  | |
| **FEV1** | **L** | **%** | **L** | **%** | **L** | **%** | **L** | **%** | **L** | **%** |
| **FVC** | **L** | **%** | **L** | **%** | **L** | **%** | **L** | **%** | **L** | **%** |
| **TLCO** | **%** | | **%** | | **%** | | **%** | | **%** | |
| **KCO** | **%** | | **%** | | **%** | | **%** | | **%** | |

|  |  |
| --- | --- |
| **6 minute walk test (if done)** **on air/oxygen:**  **Distance walked:**  **Starting sats % Lowest sats %** | \*HRCT Scan findings : |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Blood Tests:** | **Date:** | **Blood Tests:** | **Date:** | **Other relevant tests:** |
| Rheumatoid Factor: |  | ANA |  |  |
| CCP |  | ANCA |  |  |
| ENA (if positive) |  | | |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Procedure:** | **Yes** | **No** | **Location:** | **Date performed:** | **Please send reports of ALL tests (including lung function & autoimmune blds), and send ALL images via IEP to RPH** |
| **CXRs** |  |  |  |  |
| **CT Chest** |  |  |  |  |
| **Bronchoscopy/BAL/TBBs** |  |  |  |  |
| **VATs lung biopsy** |  |  |  |  |
| **Echocardiogram** |  |  |  |  |
| **Other……………………………….** |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Are they on an active RTT pathway? YES  No  \*\* IF YES PLEASE INCLUDE IPT FORM \*\*** | | | | |
| **Responsible clinician** |  | **NHS Email** |  | |
| **Date of referral** |  | **Hospital** |  | |
| **Please tick this box if you are happy for this to be used as a referral for clinic if appropriate and the patient is willing to travel to Royal Papworth Hospital** | | | |  |