

**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](mailto: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: |