**ASSESSMENT OF ELIGIBILITY FOR BRONCHOSCOPIC LUNG VOLUME REDUCTION**

**To:** Dr Alan Carew,

Wallace Street Specialist Centre

688 Gympie Rd

Chermside, QLD 4032

Re: **<Patient Name>**

 **<Patient Address>**

 **<DOB>**

 **<DVA/Medicare No>**

 **<Phone>**

**<Date>**

Fax: (07) 3188 5285

Email: info@wallacestreet.com.au

Dear Dr Carew,

Thank you for seeing **<Patient Name>**, **<Age>** years old, to assess their eligibility for bronchoscopic lung volume reduction.

**<Clinical Details>** *(i.e. COPD / Emphysema, symptoms (dyspnoea / SOB on minimal exertion mMRC ≥ 2), current inhaler therapy, smoking history, exacerbation history, spirometry if known with FEV1 ≤ 59%).*

**<Patient History>**

**<Other Past Medical History>**

**<Other Relevant Information>**

Yours Sincerely

**<Referring Doctor Name>**

**<Provider Number>**

**<Contact Details>**

**Please contact us if this patient does not attend.**