PULMONARY REHABILITATION REFERRAL FORM

BOC
A Member of The Linde Group

Name:
DOB:
NHS No:
Address:

Post Code:
Tel No:

GP:
GP Practice:

GP Tel No:

Medical History (List or attach a GP summary sheet of current problems and past medical history)

Medications (List or attach copy of current prescription)

Exclusion Criteria: (please tick Yes or No)

Y	N	Exclusion criteria
		Unstable angina
		Acute LVF
		Uncontrolled hypertension/arrhythmia
		MI within 6/52 of commencing rehab
		Compliance issues

MRC: SpO2 (at rest):

Smoking Status: Smoker / Non-smoker / Ex-smoker

Pack Years :

Height (m) : Weight (kg) : BMI:

Spirometry Results

Date:

FEV1 ________ l/min ________ % Pred

FVC ________ l/min ________ % Pred

FEV1/FVC ________ %

Oxygen

LTOT: Yes / No _____ litres/min _____ hours/day

ABOT: Yes / No _____ litres/min

Informed consent given and motivated to attend? Yes / No (Please attach signed copy of consent form)

Able to provide their own transport? Yes / No

Able to use public transport? Yes / No

Preferred Venue

St Patricks Community Hall Nuthall ☐ The Pearson Centre Beeston ☐

Referrer's signature:

Date of referral:

Name (print):

Designation:

Contact Number:

Please send completed Referral Form and Consent Form to:

The Pulmonary Rehabilitation Team Fax No: 08000 224 991

BOC: Living healthcare

HLC/604265/CLI/0416