HEART FAILURE 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 IHD/angina
		Awaiting cardiac surgery
		Uncontrolled hypertension /arrhythmia
		MI within 6/52 of referral
		Significant aortic stenosis/aneurysm
		New onset AF

NYHA Class: SpO2 (at rest):

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

Pack Years :

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

Echocardiogram Results

Date:

LVEF ________ %

Diagnosis of LVSD confirmed on Echo? Yes / No

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:

HLC/604270/CLI/0416

Please send completed Referral Form and Consent Form to:

The Pulmonary Rehabilitation Team Fax No: 08000 224 991

BOC: Living healthcare