

**Great Yarmouth and Waveney NHS Community Respiratory and Pulmonary Rehabilitation  
Service - Referral Form**

Community Respiratory (Home Oxygen Assessment and Review) Service	Pulmonary Rehabilitation (Exercise & Education)
<b>Inclusion Criteria</b> <ul style="list-style-type: none"> <li>→ SpO2 &lt; 92% at rest on room air</li> <li>→ SpO2 &lt; 90% on exertion</li> <li>→ Confirmed respiratory diagnosis</li> <li>→ Patients with severe airflow obstruction</li> <li>→ Medically optimised</li> <li>→ Exacerbation-free in preceding <b>8 weeks</b>.</li> <li>→ In patients with clinical evidence of peripheral oedema, polycythaemia (haematocrit&gt;55%) or pulmonary hypertension, referral for assessment may be considered at SpO2 levels &lt;94%</li> </ul>	<b>Inclusion Criteria</b> <ul style="list-style-type: none"> <li>→ Confirmed diagnosis of chronic lung disease (COPD, bronchiectasis, ILD, chronic asthma, chest wall disease) or pre/post thoracic surgery</li> <li>→ MRC 3 or above (MRC 2 accepted if symptomatic &amp; disabled by their condition)</li> <li>→ Mobilises independently with or without walking aid</li> <li>→ Optimised medical therapy for disease severity</li> </ul> <b>Exclusion Criteria</b> <ul style="list-style-type: none"> <li>→ Unstable angina/cardiac disease</li> <li>→ Acute LVF</li> <li>→ Abdominal aortic aneurysm &gt;5.5cm</li> <li>→ Uncontrolled hypertension/arrhythmia</li> <li>→ MI within last 6/52</li> <li>→ Unable to walk safely (e.g. arthritis, balance problems)</li> <li>→ Compliance issue (e.g. dementia)</li> </ul>

Patient informed consent to:	Yes	No	Not asked
Referral			
Share information in on SystmOne			
Share information out on SystmOne			
SMS contact			

Patient Details and supporting Information				
Name		GP Practice		
DOB		Named GP		
Address		Patient offered supporting information about the referral?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
NHS No.		Patient motivated to attend course?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Home Tel No.		Hearing impairment	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Mobile No.		Visual impairment	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Email Address		Preferred location for Pulmonary Rehabilitation	Great Yarmouth <input type="checkbox"/>	
Language Requirement			Lowestoft <input type="checkbox"/>	

<b>Clinical History (Please attach GP summary where able including past medical history and current medications)</b>		
Diagnosis/Presenting Problem		
Past medical history (List or attach GP summary)		
Current Medication (List or attach GP summary)		
Recent Results (e.g. x-rays or bloods in the last 3 months). <i>For any significant cardiac history please attach <b>last</b> ECHO report, ECG and relevant cardiology letters as able</i>		
Last Ejection Fraction (if known)		%

<b>Spirometry Results (please attach print-out)</b>				
FEV1		l/min		% predicted
FVC		l/min		% predicted
FEV1/FVC		%		

Pulse oximetry on room air	%
MRC Dyspnoea Scale (1-5)	
Smoking status	
BMI	

Is the patient medically optimised?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Is the patient exacerbating?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Exacerbation or respiratory-related admission within last 4 weeks?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
History of mental health e.g. anxiety, panic attacks, depression?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Is the patient on oxygen therapy?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If Yes, please state:		
Is the patient GP summary attached?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Reason for referral (more than one option can be selected)			
Oxygen Assessment	<input type="checkbox"/>	Pulmonary Rehabilitation	<input type="checkbox"/>

Referrer	Name		Source	Primary care	
	Job title			Secondary care	
	Organisation			Requested by secondary care	
	Telephone No.			Community team	
	NHS.net email			Other	
	Date				