

West Norfolk NHS Pulmonary Rehabilitation Service Referral Form

Pulmonary Rehabilitation	
Inclusion Criteria <ul style="list-style-type: none"> → Confirmed diagnosis of chronic lung disease (COPD, bronchiectasis, ILD, chronic asthma, chest wall disease) or pre/post thoracic surgery → MRC 3 or above (MRC 2 accepted if symptomatic & disabled by their condition) → Mobilises independently with or without walking aid → Optimised medical therapy for disease severity 	Exclusion Criteria <ul style="list-style-type: none"> → Unstable angina/cardiac disease → Acute LVF → Abdominal aortic aneurysm >5.5cm → Uncontrolled hypertension/arrhythmia → MI within last 6/52 → Unable to mobilise safely (e.g. arthritis, balance problems) → Compliance issues (e.g. dementia)

Pulmonary Rehabilitation Service Overview
<p>We offer a tailored programme of exercise and education to improve the patient's exercise tolerance and functional performance, to reduce their symptoms and their disability with the aim of improving their quality of life and promoting self-management. Each patient will be individually assessed prior to being offered a course in a local venue. Pulmonary Rehabilitation consists of 1 supervised session per week for 6 weeks, with an individually prescribed home exercise programme.</p>

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	Kings Lynn <input type="checkbox"/>	
Language Requirement			Downham Market <input type="checkbox"/>	

Clinical History (Please attach GP summary where able including past medical history and current medications)		
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 last ECHO report, ECG and relevant cardiology letters as able</i>		
Last Ejection Fraction (if known)		%

Spirometry Results (please attach print-out)				
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"/>

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