BOC
A Member of The Linde Group

NHS

Pulmonary Rehabilitation Referral Form

Patient details

Name

DOB

NHS number

Address

Postcode

Tel number (home)

Tel number (mobile)

Email address

Has your patient consented to this referral?

☐ Yes ☐ No

Has your patient consented to share their records on SystmOne?

☐ Yes ☐ No (If No, please supply GP summary)

Does the patient meet all the following inclusion criteria?

- → 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 and disabled by their condition)
- → Mobilises independently with or without walking aid
- → Is on optimal medical therapy for disease severity
- → Does not require transport
- → Motivated to attend and complete the sessions

Exclusion criteria

- → Unstable angina/cardiac disease
- → Acute LVF
- → Abdominal Aortic Aneurysm >5.5cm
- → Uncontrolled hypertension/arrhythmia
- → MI within last 6/52
- → Unable to walk safely (e.g arthritis, balance problems)
- → Compliance issue (e.g dementia)

Spirometry results (please attach print out including graph)

FEV1 l/m % pred

FVC l/m % pred

FEV1/FVC %

MRC Breathlessness Scale (please tick which applies)

1 ☐ Not troubled by breathlessness except on strenuous exercise
2 ☐ Short of breath when hurrying or walking up a slight hill
3 ☐ Walks slower than contemporaries on level ground because of breathlessness, or has to stop for breath when walking at own pace
4 ☐ Stops for breath after walking about 100 metres or after a few minutes on level ground
5 ☐ Too breathless to leave the house, or breathless when dressing or undressing

Current medication (please list or attach print-out)

Medical history (please list or attach print-out)

Is the patient known to a Community Matron?
☐ Yes ☐ No

Does the patient have a history of
☐ Anxiety ☐ Panic attacks
☐ Depression

Is the patient on Oxygen?
If yes ☐ LTOT ☐ SBOT ☐ Ambulatory

l/m hrs/day

Other information or any special requirements?
e.g language

Referrer details

Name

Job title

Referrer contact number

Referrer address

GP name (if different from referrer)

GP practice

GP tel no

GP Email address

Incomplete referral forms will be returned to the referrer.

Any queries/questions, please ring 0800 012 1858
Email completed referrals, plus patient summary to
BOC.ClinicalServices@nhs.net
Fax completed referrals, plus patient summary to:
0845 600 0096

BOC: Living healthcare

BOC Healthcare
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