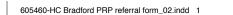






Pulmonary Rehabilitation Referral Form

Patient details	Exclusion criteria		
Name	 → Unstable angina/cardiac disease → Acute LVF → Abdominal Aortic Aneurysm >5.5cm 		
DOB			
NHS number	→ MI within la	,	·
Address	→ Compliance	e issue (e.g deme	rthritis, balance problems) ntia) ch print out including graph)
	FEV1	l/m	% pred
Postcode	FVC	l/m	% pred
Tel number (home)		•	
Tel number (mobile)	FEV1/FVC	0/0	
Email address	MRC Breathles	sness Scale (plea	se tick which applies)
Has your patient consented to this referral? ☐ Yes ☐ No	 Not troubled by breathlessness except on strenuous exercise Short of breath when hurrying or walking up a slight hill Walks slower than contemporaries on level ground because of breathlessness, or has to stop for breath when walking at own pace Stops for breath after walking about 100 metres or after a few minutes on level ground Too breathless to leave the house, or breathless when 		
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?	dressing o	or undressing	
 → 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 	Current medica	ation (please list	or attach print-out)
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 			





	Referrer details
Medical history (please list or attach print-out)	Name
	Job title
	Referrer contact number
	Referrer address
	GP name (if different from referrer)
Is the patient known to a Community Matron? ☐ Yes ☐ No	GP practice
Does the patient have a history of ☐ Anxiety ☐ Panic attacks ☐ Depression	GP tel no GP Email address
Is the patient on Oxygen? If yes □ LTOT □ SBOT □ Ambulatory I/m hrs/day	Incomplete referral forms will be returned to the referrer.
Other information or any special requirements? e.g language	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

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Pulmonary Rehabilitation Service, Priestley Road, Worsley, Manchester, M28 2UT United Kingdom Tel 0800 0121858, 0845 600 0096, BOC.ClinicalServices@nhs.net, www.bocclinicalservices.co.uk

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