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Referral Form: North Lincolnshire Community Respiratory Service

Referral Reason	Tick	Sections to Complete
Pulmonary Rehabilitation	☐	1, 2, 5
Home Oxygen Assessment & Review	☐	1, 3, 5
Chronic Respiratory Disease Management	☐	1, 4, 5

Section 1 *Patient Summary can be included

Patient Details					
Title		First Name		Surname	
NHS No			DOB		
Address					
Postcode			Home Tel No.		
Mobile No.			Email		
GP Details					
GP Practice					
Address					
Postcode			Tel		
Clinical Details					
Diagnosis					
PMH*					
Medication*					
Latest Spirometry – include print out					
FEV1			% Pred		
FVC			% Pred		
VC					
FEV1/FVC					
PEFR			Date Performed		
			Date of last spirometry & result of CXR and Eosinophils		
Observations					
Height					
Weight			BMI		
BP			SpO2 (Air)		
HR			SpO2 (O2)		
Rhythm	Reg/Irreg*		Smoker?	☐ Yes ☐ No	

MRC Scale	
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

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Section 2 – Pulmonary Rehabilitation referrals only

Does the patient meet the PR Inclusion Criteria? → Confirmed diagnosis of Chronic Lung Disease (COPD, Bronchiectasis, ILD, Chronic Asthma, Chest Wall Disease, Pre/Post Thoracic Surgery) → MRC 3 (MRC 2 if symptomatic/disabled by their condition) → Mobilises independently with or without walking aid → Is on optimal medical therapy for disease severity → Does not require transport (unless meets criteria for PTS) → Motivated to attend and complete the sessions	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No

Does the patient have any exclusion criteria? → Unstable angina/cardiac disease → Acute LVF → Uncontrolled hypertension/arrhythmia → Aneurysm requiring surgery or monitoring → MI within last 6/52 → Unable to walk safely (e.g arthritis, balance problems) → Compliance issue (e.g dementia) *NB: Referrals will be rejected if they meet exclusion criteria*	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
Does the patient agree to attend twice- weekly sessions of tailored exercises and education for a 6-week period?	☐ Yes ☐ No
Has the patient been provided with a Pulmonary Rehabilitation information leaflet? Available from www.bocclinicalservices.co.uk	☐ Yes ☐ No

Section 3 – Home Oxygen Assessment & Review

		Comments
Does the patient have a confirmed diagnosis requiring Home Oxygen Therapy?	☐ Yes ☐ No	
Is the patient medically optimised for their disease severity?	☐ Yes ☐ No	
Has the patient had an exacerbation within the last 8 weeks? *Referrals will be rejected if the patient has exacerbated within the last 8 weeksas per BTS guidelines.* *Review patient 8 weeks post-exacerbation and repeat SpO2 prior to referring.*	☐ Yes ☐ No	
Date of last exacerbation		
Oxygen saturations at rest on room air		
Oxygen saturations on exertions on room air		
Has the patient been provided with a HOS-AR information leaflet? Available from www.bocclinicalservices.co.uk		☐ Yes ☐ No

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Section 4 – Chronic Respiratory Disease Management

		Comments
Number of exacerbations in last 12 months		
Number of admissions in last 12 months		
Date of last exacerbation		
Please include most recent results (if available)	☐ CXR ☐ FBC ☐ BNP	
Reason for referral		

Patient Specific Direction (PSD) template – Spirometry Reversibility Testing:

I authorise the named patient…[insert patient name and NHS number].....to receive the following short acting bronchodilator for the purpose of reversibility testing / post bronchodilation spirometry:

Name of Medication	Salbutamol metered dose inhaler
Dosage	400 micrograms
Frequency	Once only
Method of administration	Inhalation with Volumatic Spacer Device

and that this can be administered by the Health Care Professional who is suitably qualified to do so and is employed by Community Respiratory Service - BOC Healthcare

Prescriber Name	
Signature	
Qualifications	
Date	

Section 5 – Other Information & Referrer Details

		Comments
Is the patient registered for myCOPD?	☐ Yes ☐ No	
If yes, please state myCOPD patient user key:		
Are there any known lone-worker or staff safety concerns?	☐ Yes ☐ No	
Does the patient have any communication difficulties or language requirements?	☐ Yes ☐ No	
Is the patient housebound?	☐ Yes ☐ No	

Is the patient under the care of a Community Matron?	☐ Yes ☐ No	
Does the patient consent to share their record on SystmOne? (for those GPs on S1, if not please supply a GP summary with the referal)	☐ Yes ☐ No	
Any other information or special requirements relevant to the referral?		

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Referrer Details			
Referrer Name			
Address: ☐ Same as GP Practice			
Tel Number		Fax (SafeHaven)	
Email Address (@nhs.net only)			
Preferred method of communication	☐ Email (@nhs.net only) ☐ Fax (SafeHaven fax number only) ☐ SystmOne Task & Letters/Communications ☐ Other.....		

Incomplete referral forms will be returned to the referrer. Any queries/questions, please call 0800 012 1858
Fax or e-mail completed referrals, plus patient summary, to 0845 600 0096 (SafeHaven) or BOC.ClinicalServices@nhs.net