TRAFFORD COUNCIL

NHS Pennine Care NHS Foundation Trust

Pulmonary Rehabilitation Referral Form

IMPORTANT: Email this form to tspoa1@nhs.net : Telephone: 0300 323 0303 Option 1 then 7

Referral Date: …………………..

Referrer: (Please tick) G.P. ☐ Practice Nurse ☐ Respiratory Nurse ☐ Physiotherapist ☐ Consultant ☐ Other……………..

Referrer (print name):………………..………………………………………………………………………

Referrer's contact address:……………………………………………………………………………………

Signature of Referrer: …………………………………………… **Referrer's Contact No:** ………………….

PATIENT DETAILS:

Name: Mr/Mrs/Miss/Ms …………………………………… **DoB:** ……………..…………

NHS Number: ………………………………………………

Address: ……………………………………………………………………………… **Post code:** ……………………

Patient Contact No: …………..……………………………..

Mobile No: …………………………………………………..

GP Name & Practice or Practice stamp

Does the patient have a known learning disability? Y / N

Does the patient require transport to the classes? Y / N

Does the patient give consent to sharing EMIS records between healthcare providers? Y / N

Inc / Exc Criteria (please tick Yes or No)

Y	N	Exclusion Criteria
		MI within 6/52 of commencing rehab
		Acute systemic infection
		Undiagnosed chest pain/unstable angina
		Breathlessness where cardiac cause has not been excluded
		Acute LVF
		Uncontrolled hypertension/arrhythmia
Y	**N**	**Inclusion Criteria**
		Activity limited by dyspnoea
		Able to commit to 7 week programme
		Able to work independently in a group

Diagnosis:……………………………………………………..

Home Oxygen Yes / No
% or l/min ………………… **Hours per day** …………………..

Please attach printout of:

- **Latest spirometry**
- **Past medical history**
- **Medication list**

Referrals may be rejected if this information is not included

COPD Severity (Please Circle) (FEV$_1$ % Predicted)	**Mild** ≥ 80%	**Moderate** 50-79%	**Severe** 30-49%	**Very Severe** <30%

Mobility Status: Independent no aid / independent with aid (Please provide details) / with supervision / with assistance (please circle)

Additional information: