

Pulmonary Rehabilitation Referral Form

Eligibility - Confirmed diagnosis of chronic lung disease e.g., COPD, Bronchiectasis, Interstitial Disease, Chronic asthma. MRC 3 or above.

N.B. Patients are required to be ready, willing, and able to commit to the 6-week pulmonary rehabilitation course, attending twice a week for up to 2 hours.

EXCLUSIONS: please check to indicate the following have been excluded ☐

- | | |
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| <ul style="list-style-type: none"> Chest pain Those unable to undertake group exercise Cardiac cause of breathlessness not excluded AAA greater than 4.5cm Uncontrolled hypertension | <ul style="list-style-type: none"> Patients unwilling to attend entire programme Patients who cannot walk Unstable angina Myocardial infarction in the last 6 weeks Neurogenic disability |
|---|--|

Patient's name:	Consultant Name:
Address:	Name of GP: Name of Surgery:
Tel No.	Tel No.
Gender:	Date of Birth:
NHS Number:	BMI:

Please state confirmed respiratory diagnosis:	
Number of respiratory hospital admissions in the last 12 months:	
If this is a hospital discharge referral, please indicate expected discharge date:	

Pulse Oximetry:	Date:	Reading:	
Home Oxygen:	Long Term Oxygen Therapy?		
	Ambulatory Oxygen?		
	Oxygen Prescription:		
Smoking Status:	Never ☐	Ex-smoker ☐	Current smoker ☐
	No smoked per day:		How long since stopped smoking:

Reason for referral:
Past Medical History: <i>(please attach copy of patient summary or clinic letter if available)</i>
Medication

Spirometry Readings:

Date:	Litres	% predicted
FEV ¹		
FVC		
FEV ¹ /FVC RATIO		

MRC Dyspnoea Scale – patient's perception when they are in a stable condition
(please tick below)

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

Does this patient have any additional communication/literacy needs?

If yes, please add details:

Core Pulmonary Rehabilitation Venues: (please indicate preferred patient choice)

- ☐ Boscombe – King's Park Learning and Leisure Centre, King's Park Drive
- ☐ Bridport - Bridport Community Hospital, Hospital Lane
- ☐ Dorchester – St Mary's Church Hall, Edward Road
- ☐ Kinson – Kinson Community Centre, Pelham's Park
- ☐ Portland – Portland Community Hospital, Castle Road
- ☐ Poole – Bourne Community Hub, Arne Crescent
- ☐ Sturminster Newton – The Exchange, Old Market Hill
- ☐ Wareham – Masonic Hall, Howards Lane
- ☐ Weymouth – Weymouth Bay Methodist Church, Melcombe Avenue

Does this patient consent to be contacted directly to arrange their assessment? Yes ☐ No ☐

Name, Position & Signature of Referrer:

Date:

Extension/email address:

NB - Providers shall reject any referral received for patients not considered suitable for community based pulmonary rehabilitation. The referred will be informed. Incomplete referrals will be returned for more detail.

Primary care referrals: please send via the NHS E-Referrals system

Secondary care referrals: please send directly to DCH.pulmonaryrehab@nhs.net