

Newcastle Healthy Lungs Team

NHS Pulmonary Rehabilitation Service Referral Form

Pulmonary Rehabilitation	
<p>Inclusion Criteria</p> <ul style="list-style-type: none"> → Confirmed diagnosis of chronic lung disease (COPD, bronchiectasis, ILD, chronic asthma, chest wall disease) or pre/post thoracic surgery → MRC 3 or 4 (MRC 2 accepted if symptomatic & disabled by their condition) → Mobilises independently with or without walking aid → Optimised medical therapy for disease severity → Motivated to attend and complete programme 	<p>Exclusion Criteria</p> <ul style="list-style-type: none"> → Unstable angina/cardiac disease → Acute LVF → Abdominal aortic aneurysm >5.5cm → Uncontrolled hypertension/arrhythmia → MI within last 6/52 → Unable to mobilise safely (e.g. arthritis, balance problems) → Compliance issues (e.g. dementia)
Pulmonary Rehabilitation Service Overview	
<p>We offer a tailored programme of exercise and education to improve the patient's exercise tolerance and functional performance, to reduce their symptoms and their disability with the aim of improving their quality of life and promoting self-management. Each patient will be individually assessed prior to being offered a course in a local venue. Pulmonary Rehabilitation consists of 2 supervised session per week for 6 weeks, with an individually prescribed home exercise programme. We also offer a menu of virtual options for patients with barriers to attending a face-to-face programme.</p>	

Informed consent and motivation	Yes	No	Not asked
Referral			
Share information in on SystmOne			
Share information out on SystmOne			
SMS contact			
Patient offered supporting information about the referral?			
Motivated to attend			
Referral Type			
Routine Pulmonary Rehab Referral			
Fast Track Referral – (Hospital admission within the last 4 weeks)			
Prehab Referral – (A one off education session for newly diagnosed COPD patients)			

Preferred location for Pulmonary Rehabilitation:			
Heaton		Westerhope	

For any queries, please call: **0800 012 1858**
 Please email referrals and attachments to: BOC.ClinicalServices@nhs.net
 Incomplete referrals will be returned to referrer

Patient Details			
Name		NHS No.	
DOB		Gender	
Address		GP Practice	
Home Tel No.		Named GP	
Mobile No.		Email Address	

Special considerations	Yes	No	Unknown	Further information
Hearing impairment				
Visual impairment				
Cognitive impairment				
Mental health condition				
Low literacy				
Low digital literacy / confidence				
Communication requirement?				
Language spoken				
Interpreter required?				
Any other DEI considerations:				

Clinical History (Please attach GP summary where able including past medical history and current medications)
Diagnosis/Presenting Problem
Past medical history (List or attach GP summary)
<i>Please ensure that details of any impairments or conditions ticked above are included.</i>
Current Medication (List or attach GP summary)
Mobility – please provide details of any walking aids used, any falls in the last 12 months or any current issues with pain or balance.

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Recent Results (e.g. x-rays or bloods in the last 3 months).

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Last Ejection Fraction (if known)		%
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Spirometry Results (or attach report if available)

FEV1		Litres		% predicted
FVC		Litres		% predicted
FEV1/FVC		%		

Pulse oximetry on room air	At rest:	%	On exertion:	%
<i>Type of exertion undertaken:</i>				
MRC Dyspnoea Scale (1-5)				
Smoking status				
Height		Weight		BMI

Is the patient medically optimised?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Is the patient exacerbating?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
No. of respiratory exacerbations requiring antibiotics, steroids or both in the last 12 months:		
Admission within the last 4 weeks? (For exacerbation or other respiratory-related problem)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
No. of respiratory related admissions in the last 12 months:		
Is the patient on oxygen therapy?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, please state prescription:		

Please refer to **Pulmonary Rehabilitation Service Referral Information** for decision making tool regarding suitability of pulmonary rehab referral, more detailed inclusion and exclusion information and additional requirements.

Referral supporting information required

You do not need to include this if the consent to share boxes above have been checked and the patient's primary care provider is a user of SystmOne.

Is the patient GP summary attached?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>	Not available <input type="checkbox"/>	
Is the most recent spirometry report attached?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>	Not available <input type="checkbox"/>	
Is the discharge summary attached (if the admission box above is checked):	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>	Not available <input type="checkbox"/>	
If the patient has a significant cardiac history (in particular a diagnosis of heart failure), is the most recent attached:	ECHO report	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>	Not available <input type="checkbox"/>
	ECG report	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>	Not available <input type="checkbox"/>
	Cardiology letter	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>	Not available <input type="checkbox"/>

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Referrer	Name		Source	Primary care	
	Job title			Secondary care	
	Organisation			Requested by secondary care	
	Telephone No.			Community team	
	NHS.net email			Other	
	Date				

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