**Calderdale Pulmonary Rehabilitation**

**REFERRAL FORM**

**Please ensure all sections are completed to allow timely triage and acceptance of referral**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Name:** | | | | | **NHS Number:** | | | | |
| **Date of Birth:** | | | | | **Ethnicity:** | | | | |
| **Address:**  **Tel:** | | | | | **GP Practice:** | | | | |
| **Diagnosis:**   |  |  |  | | --- | --- | --- | | **Spirometry**: Yes  Date: | | | | FEV1 in litres and % predicted value | FVC in litres and % predicted value | FEV1/FVC Ratio (or FEV1/VC Ratio if VC higher) | | | | | | | | | | |
| **Please tick box if hospitalised for exacerbation COPD within the last 4 weeks……..….**  (BTS quality standard 3) | | | | | | | | | |
| **Inclusion Criteria: *(****Tick all that apply)* | | | | | | | | | |
| Patient given information about class and gave consent to referral | | | | | | | |  | |
| Diagnosed respiratory disease | | | | | | | |  | |
| Patients willing to commit to attending PR for 12 sessions over 6 weeks | | | | | | | |  | |
| Has not completed course in last 12 months (unless hospitalised with COPD exacerbation) | | | | | | | |  | |
| Motivated to attend and make changes to their lifestyle | | | | | | | |  | |
| Independently mobile  *(will accept patients with* *mobility aid suitable for outdoor use such as walking stick, 4 wheeled walker)* | | | | | | | |  | |
| Happy in a group environment and will actively participate in the programme | | | | | | | |  | |
| Resting oxygen saturations (spO2) above 92% *(if resting SPO2< 92% on 2 occasions to consider referral to oxygen service for assessment for LTOT as per local referral guidance).* | | | | | | | |  | |
| Have a MRC score of 2 - 5. See MRC Guidance below | | | | | | | |  | |
| **MRC Grade**  (tick as appropriate) | | **Medical Research Council Dyspnoea Score Chart (MRC)** | | | | | | | |
|  | **1** | Not troubled by breathlessness except on strenuous exercise  **Not suitable for Pulmonary Rehabilitation as MRC too low to benefit**  *(Please consider other alternative exercise programme/advice).* | | | | | | | |
|  | **2** | Short of breath when hurrying or walking up a slight hill  Only suitable if has functional restriction due to breathlessness i.e. affecting daily functional ability (BTS quality standard 3) | | | | | | | |
|  | **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 100m or after a few minutes on level ground | | | | | | | |
|  | **5** | Too breathless to leave the house, or breathless when dressing or undressing – Not suitable for class if unable to leave house due to their breathlessness. | | | | | | | |
| **Smoking History** | | | | **Body Mass Index (BMI)=**  (***Please note referrals will not be accepted for patients under BMI of 18****.*  *For patients with BMI 18-20 referral to dietitian should also be completed to support rehabilitation requirement prior to referral.)* | | | | | |
| Current smoker | | | |
| Ex -smoker | | | |
| Never smoked | | | |
| |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | **Exclusions to Pulmonary Rehab:** Please tick to confirm there are no exclusions for patient.….. | | | | | | | Acute LVF |  |  | Abdominal Aortic Aneurysm > 5.5cm  or any AAA with uncontrolled BP |  | | | Uncontrolled cardiac arrhythmia |  | Surgery within six weeks |  | | Uncontrolled angina |  | Acute / current psychotic episode |  | | Heart attack within last 3 months |  | Alcoholism affecting life |  | | Cerebral vascular accident / neurological incident within the last 3 months |  | Attending other rehab programme |  | | Pulmonary embolus / DVT within the last 3 months not receiving treatment |  | Any medical problems that prevents exercise or compliance with programme |  | | Aortic stenosis |  | Any ongoing treatment for malignancy |  |   **N.B. Patients will be excluded if they have any medical problem which prevents exercise or compliance with the programme. Please contact the team to discuss if unsure whether to refer.** | | | | | | | | | |
|  | | | | | | | | |
| **Previously Attended Pulmonary Rehabilitation Programme?**  (Please give dates & location) | | | | | | | | |
| **Current Medication list and Doses** | | | | | |  | | |
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| Past medical history: | | | | | | | | |
| **Referrer Details** | | | | | | | | |
| Name: | | | | | | Job Title: | | |
| Signature: | | | | | | Date: | | |
|  | | | | | | | | |
| **OFFICE USE ONLY** | | | | | | **DATE** | **SIGNATURE** | |
| Date referral received | | |  | | |  |  | |
| PRG Destination | | |  | | |  |  | |
| Audit Required | | |  | | |  |  | |
| Priority | | |  | | |  |  | |

Calderdale Pulmonary Rehabilitation Service, Allan House Clinic, Station Road, Sowerby Bridge

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