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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Local services contact details and respiratory conditions accepted: | | | | | | | | | | | | | | |
| Mid and West Hampshire | | Southampton | | | | | Portsmouth, Fareham & Gosport, South-East Hampshire, North Hampshire | | | | | Isle Of Wight | | |
| 0300 003 0140 | | 0300 123 3794 | | | | | 0300 123 3996 | | | | | 01983 552331 | | |
| [Respiratory-assessment@southernhealth.nhs.uk](mailto:Respiratory-assessment@southernhealth.nhs.uk) | | [Solentwest.icopd@solent.nhs.uk](mailto:Solentwest.icopd@solent.nhs.uk) | | | | | [Pulmonary-rehabports@solent.nhs.uk](mailto:Pulmonary-rehabports@solent.nhs.uk) / via S1 task recipient  **2 Pulmonary Rehab e-Referral** | | | | | [Iownt.pulmonary.rehab@nhs.net](mailto:Iownt.pulmonary.rehab@nhs.net) | | |
| COPD / Bronchiectasis / ILD / Chronic Asthma | | COPD | | | | | COPD / Bronchiectasis / ILD  (In addition for Portsmouth only: Chronic Asthma) | | | | | COPD / Bronchiectasis / ILD / Chronic Asthma | | |
| |  |  | | --- | --- | | **By sending this referral I confirm that this patient I am referring is safe to exercise in line with inclusion/exclusion criteria and has consented to the referral.** | | | ***INCLUSION CRITERIA*** | ***EXCLUSION CRITERIA*** | | * Confirmed respiratory diagnosis (see above) * Limited by breathlessness and reduced exercise tolerance (MRC >2) * Optimised drug therapy * Motivated to attend and commit to sessions twice a week for a 6-week course * Recent exacerbation WITH hospital admission (whether they have previously attended or not) * Patients who have previously attended but have significant functional deterioration compared to previous attendance * Potential candidate for / recovery from lung surgery * Pulmonary Hypertension with medical advice | * Breathlessness caused by other morbidity e.g. heart failure/IHD * Recent MI (within last 3/12) * Unstable/uncontrolled Blood Pressure >180/100 * Unstable angina / unexplained chest pain * Uncontrolled cardiac arrhythmias * Acute LVF * AAA >5.5cm * Psychiatric, cognitive or locomotor problems which would prevent participation in exercise or group setting * Co-morbidities made worse by exercise * Previous attendance within one year and stable | | | | | | | | | | | | | | | |
| Patient’s details | | | | | | | Patient’s background and culture | | | | | | | |
| Name | Full Name | | | | | | Ethnicity | | Ethnic Origin | | | | | |
|  |  | | | | | | 1st language | | Main Language | | | | | |
| DOB | Date of Birth | | | Age | Age | | Interpreter required? Interpreter required | | | | | | | |
| Sex | Gender(full) | | | | | | Military Veteran? | | | | Religion | | | |
| Address & postcode | Home Full Address (stacked) | | | | | | Referrer details | | | | | | | |
|  |  | | | | | | Referring Clinician | |  | | | | | |
|  |  | | | | | | Address | | Organisation Name  Organisation Full Address (stacked) | | | | | |
| NHS No | NHS Number | | | | | | Tel no | | Organisation Telephone Number | | | | | |
| Hospital No | Hospital Number | | | | | | Email | | Organisation E-mail Address | | | | | |
| Home tel | Patient Home Telephone | | | | | | Referral date | | Short date letter merged | | | | | |
| Work tel | Patient Work Telephone | | | | | | Date received | |  | | | | | |
| Mobile tel | Patient Mobile Telephone | | | | | |  | |  | | | | | |
| Email | Patient E-mail Address | | | | | |  | |  | | | | | |
| Preferred contact method | | | Home | | |  | Work |  | Mobile |  | | | E-mail |  |

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| **Social Information** | | | | | | |
| Social Context | Transport Issues | | Has a Carer | | Is a Carer | Lives Alone |
| Next of Kin |  | | | | | |
| NOK Address |  | | | | | |
| Relationship to Patient |  | | | | Telephone No |  |
| **Relevant Past Medical History** | | | | | | |
| **Confirmed Respiratory Diagnosis:**  COPD  Bronchiectasis  Chronic Asthma  ILD  Other (please specify) | | | | | | |
| Problems  Recent hospital admission with COPD exacerbation? If yes, please state discharge date: | | | | | | |
| **Any relevant investigations/results:**  ECG Peak Flow  Values and Investigations | | | | **Current smoking status:** Smoking  Pack year history:  Referred to smoking cessation service: Yes / No / N/A | | |
| **\*\*Spirometry details MUST be provided if referring a patient with COPD UNLESS diagnosis confirmed by Respiratory Consultant.\*\***  **Date of last spirometry:**  **FEV1: FEV1% predicted:**  **FVC: FEV1/FVC ratio:** | | | | **MRC:**  *\*\* We accept referrals for those who are functionally limited with MRC Grade 2 and above\*\** | | |
| **Current Medication History** | | | | | | |
| **Medication**: Any recent significant changes?  Medication Allergies  Please attach copy of medication record | | | | | | |
| **Latest Observations** | | | | | | |
| **Date:** | | | | | | |
| Blood Pressure (mmHg): | | Heart Rate (bpm): | | | | |
| SpO2 (%):  *\*\* Please note resting sats below 92% and NOT known to oxygen service will need referral for oxygen assessment. \*\** | | BMI (kg/m2): | | | | |
| Home oxygen user:  Yes  No  Ambulatory oxygen - Flow rate if known (l/min):  Long term oxygen – Flow rate if known (l/min): | | | | | | |
| **Any Additional Information:**  Consultations  Are there any other issues relating to risk/safety to staff and other patients?  Any specific communication needs? | | | | | | |
| **Has the patient completed the programme before? Yes**  Date:  **No** | | | | | | |
| **Reason for re-referral:**  Potential candidate for lung surgery  Recovering from lung surgery  Recent exacerbation requiring hospital admission  Significant functional deterioration compared to previous attendance | | | | | | |