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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 | Solentwest.icopd@solent.nhs.uk | Pulmonary-rehabports@solent.nhs.uk / via S1 task recipient **2 Pulmonary Rehab e-Referral** | 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 |
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| **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
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| 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 FlowValues and Investigations | **Current smoking status:** SmokingPack 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 AllergiesPlease 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:**ConsultationsAre 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 |