Pulmonary Rehabilitation Referral Form (WEST)

Please note all fields MUST be completed. Incomplete or inappropriate referrals will be returned.

Patient Details			**Referral Date:**
Title:	**First Name:**	**Surname:**	**Patient Recently discharged from hospital following an acute exacerbation: Y N**
D.O.B:		**NHS No:**	
Address:		**Home Tel No:**	
		Mobile Tel No:	**Hospital discharge date:**
Postcode:			
GP:		**GP Address:**	**GP Tel No:**

Inclusion Criteria for Pulmonary Rehabilitation	**Exclusion Criteria for Pulmonary Rehabilitation**	
• Confirmed diagnosis of COPD, Bronchiectasis, Asthma, Pulmonary Fibrosis, Sarcoidosis, Asbestosis and other lung conditions causing functional limitation due to breathlessness	• Those with an MRC of 1	• Tracheobronchomalacia
	• MI within last 6 weeks	• Untreated embolism/unstable INR
	• Severe aortic stenosis	• Uncontrolled hypertension
	• Acute /severe LVF	• Uncontrolled diabetes
• Patients pre- or post- lung surgery	• Uncontrolled cardiac arrhythmias	• Impaired cognitive ability
• Is being treated optimally for their condition	• Unstable angina	• Severe arthritis
• Has MRC score of 2 - 5	• Heart ejection fraction <35	• Severe osteoporosis
• Motivated to attend twice per week for 6 weeks	• Significant AAA > 4.5cm	• Unstable/unresolved fractures
• Able to participate in group activities	• Those awaiting a pacemaker	• Severe cognitive impairment
• Has own transport/able to get to venue	• Recent/spontaneous pneumothorax	• Ongoing drug/alcohol addiction

Diagnosed Respiratory Lung Condition:

Date & results of last lung function test: **FEV1:** **FVC:** **FEV1/FVC:**

MRC Score: **2 3 4 5**

Smoking History: **Current Smoker:** ☐ **Previous Smoker:** ☐ **Never Smoked:** ☐

Oxygen Therapy: **No** ☐ **Yes** ☐ **Unknown** ☐

If yes, please give details:

Flow rate at rest: _____

Flow rate on exertion: _____

Does the patient have a frailty score? **Y** ☐ **N** ☐

If yes, please specify (mild, moderate, severe or Rockwood Score 1-9:

Other Medical Conditions:

Current Medication:

Mobility: **Walking frame** ☐ **Walking stick** ☐ **Unaided** ☐

Able to walk more than 10 metres: **Y** ☐ **N** ☐

Additional Needs: **Hard of hearing** ☐ **Visual Impairment** ☐ **Interpreter Required** ☐

Referrer's Name: **Tel No:**

Referrer's Position:

Please return form to Care Co-Ordination Centre, 86 Sandy Hill Lane, Ipswich, Suffolk, IP3 0NA.
suffolkcommunityhealthcare.referrals@nhs.net or Tel: 0300 123 2425
We will contact the patient direct to make an appointment.

Only completed forms will be accepted.