**Hope Specialist Respiratory Service Referral Form**

**IMPORTANT: Please email completed form:**[**cpg.hopespecialistservice@nhs.net**](mailto:cpg.hopespecialistservice@nhs.net)

**Please also attach any other patient details as appropriate.**

**Patient Details:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name |  | | Date of Birth | |  |
| Address (inc. postcode |  | | NHS no. | |  |
| Contact no. |  | | Email address | |  |
| Consent to SMS |  | | Consent to email | |  |
| GP Name |  | | Practice Code | |  |
| GP Address (inc. postcode) |  | |  | |  |
|  | |  | |  | |
| Patient status (delete as appropriate): | | Outpatient | | Inpatient | |
| If Inpatient give | | Ward: | | Expected discharge: | |

**Referrer Details:**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Referrer (delete as appropriate) | | GP | | Specialist | | Other |
| Referrer (print name) |  | | Designation | |  | |
| Referrer contact no. |  | | Referral date | |  | |

|  |  |
| --- | --- |
| Reason for Referral | |
| Pulmonary Rehabilitation (MRC 2-5 | Y/N |
| Post admission fast track rehab (**patients that have been admitted to hospital following an Acute Exacerbation of COPD)** | Y/N |
| Newly diagnosed: COPD Self-Management Education programme (MRC 1-2) | Y/N |

|  |  |  |  |
| --- | --- | --- | --- |
| Diagnosis | Y/N | Date of Diagnosis | Relevant Medical History |
| COPD |  |  |  |
| Bronchiectasis |  |  |
| Interstitial Lung Disease |  |  |
| Lung Cancer |  |  |
| Other |  |  |
| **Please note we do not accept asthma only diagnosis for Pulmonary Rehabilitation** | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Exclusion Criteria | Y | N | Exclusion Criteria | Y | N |
| Unstable angina |  |  | AAA ≥ 5.5cm require clearance from surgeon/consultant |  |  |
| Acute/Unstable LVF/Cor Pulmonale |  |  | Severe uncontrolled tachycardia over 120BPM |  |  |
| Uncontrolled hypertension/arrhythmia |  |  | BMI ≤ 16 |  |  |
| MI within 6/52 of commencing rehab |  |  | Patients whose cognitive or psychiatric condition prevents them from following /retaining instructions |  |  |
| Inability to exercise due to MSK, or other conditions (E.g. severe OA or PVD |  |  |  |  |  |

**Medical History:**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| MRC |  | Height | | 1.2 m | | | | Weight | | 85 Kg | | | BMI | | 69.44 Kg/m² | | |
| Smoking status (delete as appropriate): | | | | | | Smoker | | | | | Ex-smoker | | | Never Smoked | | | |
| O2 Sats at rest, on air | | |  | | | | | | Currently on Oxygen? | | | | | | | Y/N | |
| Hospital Admission in last 12 months? | | | | | Y/N | | Date of last admission | | | | |  | | | | | |
| To your knowledge, is there any reason why this patient should not be visited by a lone member of staff? | | | | | | | | | | | | | | | | | Y/N |
| If yes, please state reason: | | | | | | | | | | | | | | | | | |

**Additional Information:**

|  |  |
| --- | --- |
| Has the patient been informed about this referral and consented to assessment and treatment by the Hope Specialist Respiratory Team? | Y/N |
| Has the patient been given a Hope Specialist Respiratory Service leaflet? | Y/N |
| Any special requirements or considerations? | Y/N |
| If yes, please give details: | |

|  |
| --- |
| Any other comments/information: |

*Form Revised June 2014 Review Date: June 2015*