

**YORK PULMONARY REHABILITATION REFERRAL FORM – to be emailed to:**

[**yhs-tr.yorkrespiratoryphysiotherapy@nhs.net**](mailto:yhs-tr.yorkrespiratoryphysiotherapy@nhs.net)

**We rely on the information you provide to triage our referrals effectively. Please ensure this form is fully completed before sending. Incomplete referrals will be returned.**

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| \* Name: \* Address:  \*Postcode:  \*Tel no:  Email address:  \*Gender: \*Ethnicity: | | | \* NHS No:  \* DOB:  \* GP:  Age:  Respiratory Consultant: | |
| Has the patient consented to this referral? \* YES 🞏 NO 🞏  **Is this referral: Urgent / Routine (please delete as necessary)**  **If Urgent please state reason:** | |
| \* Reason for referral / Confirmed Respiratory Diagnosis:  Asthma □  COPD □  Bronchiectasis □  ILD □  LVRS □  Lung Transplant □  Emphysema □  Lobectomy □  Other diagnoses □…………………….. | | | \* Date of last Exacerbation for Respiratory Condition:  \*Date of last Hospital admission for COPD Exacerbation:  \*Date of Discharge for this admission:  Number of hospitalisations in last 12 months:  Number of exacerbations in last 12 months:  **Does this patient have a DNACPR in place?** | |
| \* Medical History:  Does this patient have a current mental illness or cognitive impairment? | | | | |
| Social History: | | \*Respiratory Medications:  Other medications: | | |
| Smoking History:  Previous Pulmonary Rehab: Yes/No  Completed programme? Yes/No  Date completed:  Exercise tolerance: | | Walking aids:  Osteoporosis:  Recent # or falls: | | |
| Home O2 and type/flow: LTOT: □ L/min……....…hours/day………….  Ambulatory: □ L/min……....…hours/day………….  Short burst: □ L/min……....…hours/day…………. | | | | |
| \* Spirometry date:  FEV1:    FEV1% predicted (10-125%):  FEV1/FVC ratio ((0.20-0.95): | \*MRC Score | | | \* HR |
| \*Weight | | | \* BP |
| \*Height | | | \* SaO2 |
| **REFERRER’S DETAILS \***  **Name (please print): Signature:**  **Designation: Location:**    **Contact No: Date:** | | | | |

**MRC Dyspnoea Scale**

1. Not troubled with breathlessness except with strenuous exercise.
2. Troubled by breathlessness when hurrying on the level or walking up a slight hill.
3. Walks slower than people of the same age on the level because of breathlessness or has to stop for breath when walking at own pace on the level.
4. Stops for breath after walking about 100 yards after a few minutes on the level.
5. Too breathless to leave the house or breathless when dressing or undressing.

**Referral Criteria**

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| **Inclusion Criteria** | **Exclusion Criteria** |
| * 18 years of age and over * Agree to attend full programme consisting of face-to-face assessments and 12 exercise and education sessions. * Confirmed Respiratory diagnosis. * Optimised inhaled therapy. * MRC score of 3 or above or exercise limitation to daily activities for MRC 2. * Hospital admission due to respiratory exacerbation. * Registered with a Vale of York GP surgery. | * Under 18 years of age. * Cognitive impairment that restricts compliance to group activities. * Loco motor disability that would inhibit any form of exercise. * Unstable angina/ cardiac disease. * MI in last 3 months. * Second and third degree heart block. * Acute coronary syndrome. * Recent embolism within 8 weeks. * Abdominal Aortic Aneurysm (> 5.5cm). * Significant aortic stenosis. * Uncontrolled hypertension. * Not committed to attend the full programme. * The service is **unable** to accept referrals for individuals who have completed Pulmonary Rehab within the last 6 months, (this does not include individuals who have had a hospital admission with a respiratory exacerbation). The service is only able to accept referrals **after 12 months of completion date** if the individual’s condition has clinically deteriorated. |