Doncaster and Bassetlaw Hospitals NHS
NHS Foundation Trust

PULMONARY REHABILITATION REFERRAL FORM

Name: .... Date of Birth: ....
NHS number: .... Telephone number: ....
Address: ....

Respiratory Consultant (if applicable): ....
GP Name: .... GP Address: ....
GP Telephone number: ....

Inclusion Criteria (tick any relevant) - Pulmonary rehabilitation may be appropriate if the patient has:

☐ Breathlessness that limits functional ability, secondary COPD (usually MRC 3 or greater)

☐ Optimised respiratory medical management, according to NICE guidance and is clinically stable

☐ Confirmed respiratory diagnosis

☐ Consented to being referred

☐ Motivation to complete the programme

Exclusion Criteria; please see exclusion criteria listed below.
Pulmonary Rehabilitation is not appropriate if the patient has;

- Uncontrolled cardiac condition
- Recent (within 3 months or untreated) Pulmonary TB
- Serious cardiac event in the last 6 weeks
- Other medical problem that may severly restrict exercise or compliance e.g dementia

MRC Dyspnoea Scale (please tick relevant level for the patient)

☐ 1. Breathless with strenuous exercise

☐ 2. Short of breath when hurrying on the level or walking up hill

☐ 3. Walks slower than people of the same age on the level because of my breathlessness or have to stop when walking at own pace on the level

☐ 4. Stops for breath after walking 100m or after a few minutes on the level

☐ 5. Too breathless to leave the house, or breathless dressing and undressing

Smoking History (please tick)

☐ Never smoked

☐ Ex-smoker

☐ Current smoker

If the patient has smoked:

Number smoked per day: ....

Number of years smoking: ....

Spirometry (please complete)	Date	If available please attach a copy of a recent Spirometry trace
FEV1		
FVC		
FEV1/FVC		
Predicted %		

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Patient Name: .... Patient NHS number: ....

Clinical Details

Respiratory Diagnosis: ....

Other relevant co morbidities or past medical history: ....

Allergies: ....

Weight: .... Height: .... BMI: ....

Health care professional involvement (please tick):

Please specify:

- ☐ District nurse ....
- ☐ Community repiratory nurse ....
- ☐ Community matron ....
- ☐ Dietitian ....

Hospital Admissions (please provide details of hospital admissions over the past 12 months): ....

....

Medications (please tick and provide information below):

- ☐ Beclomethasone
- ☐ Budesonide
- ☐ Fluticazone
- ☐ Salmeterol
- ☐ Formoterol
- ☐ Salbutamol
- ☐ Seretide
- ☐ Other medication: ....
- ☐ Symbicort
- ☐ Terbutaline
- ☐ Ipratropium
- ☐ Tiotropium
- ☐ Theophylline
- ☐ Oral steroids

Oxygen Therapy ☐ Yes ☐ No

If yes please provide details:	litres/min	hrs/day
☐ LTOT	....	....
☐ Short Burst	....	....
☐ Ambulatory	....	....

Previous Non Invasive Ventilation (please indicate whether the patient has had previous NIV) ☐ Yes ☐ No

If yes please provide details: ....

Referral Details

Name of referrer: .... Job Title: ....

Referrer contact number: ....

Patient has a COPD Handbook ☐ Yes ☐ No

Patient provided with a PR leaflet ☐ Yes ☐ No

Patient attended a previous PR programme? If yes, please provide details: ....

Other considerations e.g. interpreter/ transport/ carer required: ....

Referrer signature: .... Date: ....

Please fax to physio department at Mexborough Montagu Hospital 01709 321173