PULMONARY REHAB REFERRAL

Please ensure the following criteria are met prior to referral:

- Diagnosis is confirmed
- Inhaler therapy is optimal with good inhaler technique
- Pulmonary rehab has been discussed with the
- Patient is willing to attend (twice a week for six weeks)
- Patient has transport to and from the programme or is able to use an online communication platform (e.g. Zoom)
- MRC score of 3 or above
- Any condition preventing an increase in level of exercise should be fully investigate & stable prior to referral e.g. heart failure, angina, diabetes

Source of referral:	**Date referral received:**	**Date of Assessment:**

Name:	
Address: **Tel No:**	
DOB:	
H&C:	
NoK: **Tel No:**	
GP: **Tel No:**	

Diagnosis:
Past Medical History: Reviewed at assessment:

Drug Allergies or other Allergies:

Medications:

Inhaled :
Nebulised:

Oxygen: **Yes/No**
LTOT/AMB:

Reviewed at assessment:

Baseline SPo2 on _____ LPM / RA Baseline Pulse_____ Respiratory Rate _____	Baseline BP _____ **Weight:** **Height:** **BMI:**

Spirometry (Date)			
	FEV1 (1/min)	FVC (1/min)	Ratio
Actual			
% Predicted			

Social / Family History: (family support, accommodation, hobbies)

Reviewed at assessment:

Smoking History:

Sign:	**Print Name:**	**Date:**

All sections MUST be completed

Completed forms to be sent to: Community Respiratory Team

Lisburn	**Down**	**North Down and Ards**
GPOOH	**Short Stay Unit**	**Bangor Admin Building**
Respiratory Team	**Respiratory Team**	**Newtownards Road**
Lagan Valley Hospital	**Downe Hospital**	**Bangor**