 **GP / Healthcare Professional Referral Form**

The form should only take about 5 minutes. Please tick the option below:

Please complete: \*

I am a GP/ health professional making a referral\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you are making the referral on behalf of someone else: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Role: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referral Purpose:

Pulmonary Rehab Y/N Mental Health Y/N

**Patient Profile**

NHS number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

▪ Given Name/ Forename: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Family Name/ Surname: \_\_\_\_\_\_\_\_\_

▪ Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address Line 1: \*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address Line 2 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Town/City: \*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

County: \*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Postcode: \*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

▪ Contact phone number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency contact details: ▪**

**Patient has difficulty to read and write in English? \* Yes/No/Unknown**

**Patient is a registered carer for someone else? \* Yes/No/Not Stated**

**Previously completed Pulmonary rehabilitation\* Yes/No**

**Provider details:**

**Does the patient meet all the following inclusion criteria? (Please tick to confirm)**

• Confirmed medical diagnosis of chronic respiratory condition (COPD, ILD, Chronic Asthma, Bronchiectasis)

or Pre/Post Thoracic Surgery

• Optimised medical therapy for respiratory and mental health conditions as per NICE guidelines.

• If smoking, consent to initiatives to reduce or quit smoking

• If on long term oxygen therapy, ambulatory oxygen must be prescribed.

• Priority will be given to those with an FEV < 50% of predicted value, CAT score 20 and above, MMRC- 3 with 1 hospitalisation > 2 weeks per 6 months (MRC 2 accepted if symptomatic and disabled by their condition)

• Priority will be given to people who have not already completed a course of pulmonary rehab.

• Informed consent to pulmonary rehabilitation and mental health therapy with an understanding that it requires motivation and active participation.

**Spirometry results (please attach print out of last spirometry results)**

FEV1 l/m % pred\_\_\_\_\_\_\_\_\_

FVC l/m % pred\_\_\_\_\_\_\_\_\_\_

FEV1/FVC %\_\_\_\_\_\_\_\_\_\_\_\_\_

DLCO % pred\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MMRC Breathlessness Scale (please tick which applies)**

0 Not troubled by breathlessness except on strenuous exercise

1 Short of breath when hurrying or walking up a slight hill

2 Walks slower than contemporaries on level ground because of breathlessness, or has to stop for breath when walking at own pace

3 Stops for breath after walking about 100 metres or after a few minutes on level ground

4 Too breathless to leave the house, or breathless when dressing or undressing

**Details of symptoms (include baseline O2 levels with and without Oxygen (if prescribed)- insert small box to tick**

Breathlessness

Sputum

Fatigue

Pain

Mood Swings

Sleep apneas

Other- Blank box

**Date of symptom onset**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

▪ Current 0₂ Sats at rest (if known) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Prescribed with short burst oxygen / long term oxygen/ Exercise Oxygen

L/min\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hrs/day\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Prescribed with BiPAP/CPAP: \_\_\_\_\_\_\_\_\_\_\_\_\_ Date Prescribed\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have completed any exercise endurance test previously ▪ Yes/no**

 If so, please tick:

Sit-to-stand test/6 Min walk test/ Incremental Shuttle Walk test/Endurance Shuttle Walk test

Date of last test \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Distance Walked\_\_\_\_\_\_\_\_Km/M

Lowest O₂ Sats during one-minute: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications (include O2 prescription): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Other significant information**

Patient lives alone \* Yes /No

Patient lives in apartment/ house/ bungalow?

Patient Smoke/ Chew tobacco: Yes/No?

If yes for smoking, specify the type: Cigarettes, cigars, bidis, kreteks, pipe or hookah

No of cigarettes per day\_\_\_\_\_\_\_\_\_ No of Years\_\_\_\_\_\_\_\_\_

Patient drink alcohol \* Yes/ No

 If yes, how many bottles/ glasses/week\_\_\_\_\_\_\_\_\_\_\_\_?

Patient have any mental health issues \* Yes / No?

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

▪ COVID-19 test result, if available or date test appointment\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Where did you hear about the service? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

▪ Consent to share

I understand that the information I provide will be stored securely as a part of patient medical record in Lung Rehab Voyage. If required any part of information provided in the referral will be shared with relevant medical/ healthcare professionals for purpose of care management with best interest of patient health and quality of life care and improvement.

Yes/No

*Thank you for completing the referral. Please give us 48 hours to respond. Thanks in advance for your patience.*

**Official Service use (please leave blank):**

Does patient live alone? Yes /No

Does patient lives apartment/ house/ bungalow?

Emergency contact details: ▪ Carer/Friend/Family-name and contact phone number