**Lung Rehab Voyage Self Referral Form**

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

Self-referral Purpose

Pulmonary Rehab Y/N Mental Health Y/N

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

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

▪ Family Name/ Surname: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

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

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

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

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

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

GP name (if known): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

GP Practice: \*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Permission to send written communication to Email/ letter: \* Yes/No

Home Phone Number: \_\_\_\_\_\_\_\_\_\_Mobile Phone Number: \*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Permission to receive texts/ Voicemail/ email: Yes/No

Email address: We will use your email to communicate important information about our service, such as appointment times and questionnaires to be completed prior to your appointments. We do not use your email address for any other purpose and never sell your information to any third party.

Do you live alone? Yes /No

Do you live in apartment/ house/ bungalow?

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

Do you have difficulty read and write in English? \* Yes/No/Unknown

If yes, please brief the reasons:

Do you have a disability/ special requirement? \* Yes/ No

If yes, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you a registered carer for someone else? \* Yes/No/Not Stated

Do you 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\_\_\_\_\_\_\_\_\_

Do you drink alcohol \* Yes/ No

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

Do you have any mental health issues \* Yes / No?

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

If you are a registered carer, please can you tell us which condition the person you care for has: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Do you have any of the following long term medical conditions? \*(tick) insert boxes for each question below

Chronic Bronchitis/ Emphysema/Asthma/Interstitial Lung Disease/ Bronchiectasis/ Pulmonary Hypertension/ Cystic Fibrosis/ Lung Cancer/Pre/Post Thoracic Surgery

Multiple long-term conditions, please specify: Diabetes/ heart disease/Bowel disease/ Fibromyalgia/ other -specify

Date of Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last Chest X-ray\_\_\_\_\_\_\_\_\_\_\_\_

Height\_\_\_\_\_\_\_\_\_\_ cm/ft Weight\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Kg/St/Ibs

Spirometry results (if you have results copy, please attach)

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

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

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

DLCO % Pred\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Do you have MMRC 3 or above (MRC 2 accepted if symptomatic and

disabled by their condition) Yes/No

Do you Mobilise independently with or without walking aid? Yes /No

Are you Motivated to attend and complete the sessions?

▪ 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): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

▪ General text box for any other significant information

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 a medical record of Lung rehab voyage. If required my information provided in this referral or during consultation will be shared with relevant medical/ healthcare professionals for purpose of care management with best interest of my health and quality of life care and improvement.

Yes/No

**Cancellation policy**

We require at least 48hrs notice to amend your cancellation. Any notice under 24 hours, charges of 15% applicable scheduled service will be subjected to payment to lung rehab voyage.

I consent to cancellation policy Yes/No

Thank you for completing the referral. Please give us 48-72 hours to respond. Thanks in advance for your patience.