



Lung Rehab Voyage Self Referral Form

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

Self-referral Purpose: **Pulmonary Rehab:** Yes / No **Mental Health:** Yes / No

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 address: _____

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: _____

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?

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

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?:

- ☐ 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/lbs

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):

☐ Breathlessness ☐ Sputum ☐ Fatigue ☐ Pain ☐ Mood Swings ☐ Sleep apneas

Other: _____

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 O₂ 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 yes, 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): _____

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.