

**Name:**

**Address:**

**MRN: D.O.B.:\_\_/\_\_/\_\_**

**Phone Number:**

Pulmonary Rehabilitation

Program Referral Form

**• Date of Referral: \_\_/\_\_/\_\_ • Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**• PFTs: Date: \_\_/\_\_/\_\_ %FEV1/FVC \_\_\_\_ FEV1 \_\_\_\_% FVC \_\_\_\_% DLCO \_\_\_\_\_%**

**• MRC Score: \_\_\_/5 • if MRC <3 but patient requires education please tick box**

|  |  |
| --- | --- |
| **Grade** | **Degree of Breathlessness Related to Activities** |
| **1** | Not troubled by breathlessness except on strenuous activity |
| **2** | Short of Breath when hurrying on level ground or walking up a slight hill. |
| **3** | Walks slower than most people on the level, stops after a mile or so, or stops after 15 minutes walking at own pace. |
| **4** | Stops for breath after walking about 100 yards or after a few minutes on level ground. |
| **5** | Too breathless to leave the house, or breathless when undressing |

**Inclusion Criteria (Please tick):**

Diagnosis of Chronic Respiratory Disease (e.g. COPD, bronchiectasis, lung transplant candidates)

MRC score 3-5

No evidence of unstable asthma, ischaemic heart disease, decompensated/unstable heart failure, severe or uncontrolled systemic arterial hypertension, neuromuscular or musculoskeletal disorders or other disabling diseases that could affect exercise training.

No suspected underlying malignancy

Motivated to attend a 7-week out-patient exercise and education program in a group setting.

Safe and independent with or without mobility aid and has the ability to exercise independently with supervision

Optimisation of Respiratory Medications: Yes No

Please List Medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you discussed Pulmonary Rehabilitation with the patient? Yes No

Smoking Status: Current Smoker Ex-Smoker Never Smoked

If Smoker, has patient been referred to Smoking Cessation Officer? Yes No

Home Oxygen: Yes No \_\_\_\_ L/min \_\_\_\_ hrs/day

Portable Oxygen: Yes No \_\_\_\_ L/min \_\_\_\_\_\_ device

NB: It is essential that each patient has also been screened for the above criteria by their **Consultant/Registrar/Respiratory CNS/ANP /Respiratory Physiotherapist** and signed below.

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

Signature PRINT NAME and Bleep Number

**Send Completed forms to**:

**If patient has MRC < 3 but requires education, they will be invited to monthly education event only.**

**INCOMPLETE REFERRALS WILL BE RETURNED**