**PULMONARY REHABILITATION REFERRAL FORM**

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| **PATIENT DETAILS**  Mr/Mrs/Ms/Miss/Other: ………………………………..  Surname: …………………………………………………….  Forename: .……………………………………………………  Address: ………………………………………………………….  ………………………………………………………………………..  ………………………………………………………………………..  Postcode: ………………………………………………………..  Telephone Number: ....…………………………………….  DOB: ……..../…..……/……....  NHS number: ………………………………………………….. | **GP DETAILS**  Name: ……………………………………………………………..  Address: ………………………………………………………….  ………………………………………………………………………..  ………………………………………………………………………..  Postcode: ……………………………………………………….  Telephone Number: ………………………………………. |
| **If inpatient,** discharge date: |
| **PRIMARY RESPIRATORY DIAGNOSIS:** | |
| **MRC GRADE** (patient to select appropriate grade)  **1** - Not troubled by breathless except on strenuous exercise  **2** - Short of breath when hurrying on a level or when 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 100 yards, or after a few minutes on level ground  **5** -Too breathless to leave the house, or breathless when dressing/undressing | |
| **Please give details of any patient specific issues**  Transport required: Y/N  Oxygen user: Y/N  Translator required: Y/N  Other : ………………………………………………………………………………………………………………………………………….. | |
| **Please note the following exclusion criteria:**   * Severe or unstable cardiovascular disease * Severe mental illness * Severe orthopaedic limitation (e.g. waiting for joint replacement) | |
| **Referrer details**  Referring organisation: …………………………………………………………………………………………………………………  Referrer role: GP / Consultant / SpR / Respiratory Nurse / PT / OT / Community Team/ Other  **Signature: ………………………………………………… Print name: …………………………………………………………** | |
| **FOR OFFICE USE ONLY** Date received:…………………………………………………….  Post Exacerbation / Stable | |

**Please return to: [PR Service, Address…. Email: … Fax: …]**

**Please telephone […] with any queries.**

**Has this referral been discussed with the patient? Y/N**