**East Riding Pulmonary Rehabilitation Service**

**Referral Form**

**\*Please Note: Incomplete forms will be returned, resulting on delayed assessment\***

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Name of Referrer: | | | | | | | | | Date of Referral: | | | | | | |
| Job Title: | | | | | | | | | | | | | | | |
| Address & contact number/email of referrer: | | | | | | | | | | | | | | | |
| **PATIENT DETAILS** | | | | | | | | | | | | | | | |
| Registered GP: | | | | | | | | | GP Practice Address: | | | | | | |
| Title: | Forename: | | | | | | | | Surname: | | | | Known as: | | |
| Date of Birth: | | | | | | | | | NHS Number: | | | | | | |
| Gender: | | | | | | | | | Ethnicity: | | | | | | |
| Religion: | | | | | | |
| Address: | | | | | | | | | | | | | | | |
| Patient home number: | | | | | | | | | Patient mobile number: | | | | | | |
| Preferred contact number: Home  Mobile | | | | | | | | | Email address: | | | | | | |
| Lives alone/carers/nursing home/  residential home: | | | | | | | | | Next of Kin/Carer/Emergency contact: | | | | | | |
| **If inpatient:**  Expected discharge date: | | | | | | | | | Organisation: | | | | | | |
| Consent to contact via SMS | | | | | | | | | Yes | No | | | | | |
| Consent to contact via Email | | | | | | | | | Yes | No | | | | | |
| Consent to share medical information: | | | | | | | | | Yes | No | | | | | |
| Translator required: | | | | Yes | | | | | No | Language required\*: | | | | | |
| Chaperone required: | | | | Yes | | | | | | No | | | | | |
| Accessible information needs: | | | | Yes | | | | | No | Detail needs: | | | | | |
| Primary Respiratory Diagnosis: | | | | Client aware of diagnosis? | | | | | Yes | No | | | | | |
| Are there any other services involved in patient’s care | | | | Yes | | | | | No | Don’t know | | | | | **(If yes give details)** |
| **SUPPORTING INFORMATION** | | | | | | | | | | | | | | | |
| Is there a Lone working risk? | | | | | | | Yes | | | | No | | | | |
| Is there a Safeguarding risk? | | | | | | | Yes | | | | No | | | | |
| Has the patient given consent for the referral? | | | | | | | Yes | | | | No | | | | |
| Any concerns re Mental Capacity? | | | | | | | Yes | | | | No | | | | |
| **ReSPECT** document in place? | | | | | Yes | | No | | | **(If yes give details)** | | | | | |
| Smoking: | | | | | Yes | | No | | | Don’t know | | | | | |
| **ESSENTIAL INFORMATION** | | | | | | | | | | | | | | | |
| **OBS Mandatory (must be completed)** | | | | | | | | | | | | | | | |
| Height: | | | | | | | | RR: | | | | | | | |
| Weight: | | | | | | | | 02 Sats: | | | | | | | |
| Recent BP & Pulse**:** | | | | | | | | MRC Score: | | | | | | | |
| No. of recent hospital admissions & dates: | | | Number of admissions: | | | | | | | | Dates of admissions: | | | | |
| O2 Therapy | | Yes | | | | | | No | | | **(If yes give details)** | | | | |
| Referral for exercise or education | | Exercise | | | | | | Education | | | **Both** | | | | |
| **Has the patient had a diagnosis of Covid19** | | | Yes  date: | | | | | | | | | No | | | |
| Post covid symptoms: | | | | | | | | | | | | | | | |
| Post Covid = 12 Week – Xray completed | | | | | | Yes | | | | | | No | | | |
| **Spirometry** | | | | | | | | | | | | | | | |
| FEV1 in litres: | | FEV1 % predicted: | | | | | | FEV1/FVC ratio: | | | | | | Date: | |
| Spirometry print-out enclosed | | | Yes | | | | | | | | | No | | | |
| **Date of last Exacerbation for Respiratory Condition:** | | | | | | | | | | | | | | | |
| **Date of last hospital admission for COPD Exacerbation:** | | | | | | | | | | | | | | | |
| **Date of discharge for this admission:** | | | | | | | | | | | | | | | |
| **COMORBIDITIES** | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
| **MEDICAL HISTORY (including current medication, attach print out if possible)** | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
| **SOCIAL INFORMATION** | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
| **REASON FOR REFERRAL/CONFIRMED RESPIRATORY DIAGNOSIS** | | | | | | | | | | | | | | | |
| (e.g. post exacerbation, breathlessness management): | | | | | | | | | | | | | | | |

**To make a referral please send via email to:** [**chcp.247111@nhs.net**](mailto:CHCP.247111@nhs.net)

\* **Please note it is CHCP Policy that a family member or friend cannot be used for translation purposes\***