**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**

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