REFERRAL FORM FOR PULMONARY REHABILITATION

Please complete all sections of this form and send to
Pulmonary Rehabilitation Team, Gartnavel General Hospital, Great Western Road, Glasgow G12 0YN
Telephone Number 0141 211 3392 gg-uhb.PulmonaryRehabilitation@nhs.net
Please use SCI Gateway referral if available.

PATIENT DETAILS	GP DETAILS (or stamp)
Name:	**Name:**
Address:	**Address:**
Post Code:	**Post Code:**
Telephone No. **DOB ____/____/____**	**Telephone No.**
Hospital Consultant:	**Fax No.**
Hospital:	**Practice Code:**
Hospital No.:	**CHI No.**

Inclusion Criteria - ALL

- ❒ Diagnosis of COPD
- ❒ MRC grade 3 or greater
- ❒ On optimum drug therapy
- ❒ Motivated to participate

Exclusion Criteria – Any One

- ❒ **Successful Completion** of pulmonary rehabilitation programme within the past 2 years (Refer for return to vitality classes)
- ❒ Psychiatric, cognitive or locomotor problems that would prevent participation in exercise or in a group setting
- ❒ Decompensated heart failure

Has the patient completed pulmonary rehabilitation before? **Y** □ **N** □ If "YES" when? ____/____/____
[If less than 2 years patient will be seen for review assessment and referred to vitality class if appropriate]

Date of most recent COPD exacerbation ____/____/____ Was the patient admitted to hospital? Y □ N □

Spirometry Date: ____/____/____ FEV1 (post bronchodilator) _____ % predicted

MRC dyspnoea scale (must be 3 or greater) **circle as appropriate**
Grade 1: Not troubled by breathlessness except on strenuous exercise
Grade 2: Short of breath when hurrying or walking up a slight hill
Grade 3: Walks slower than contemporaries on level ground because of breathlessness, or has to stop for breath when walking at own pace
Grade 4: Stops for a breath after walking about 100m or after a few minutes on level ground
Grade 5: Too breathless to leave the house or breathlessness when dressing or undressing

Patient's medication – please ensure treatment is optimal before referral – see NHSGGC guideline

Oral	Inhaled	Nebulised

Oxygen Therapy - Ambulatory Y ❒ N ❒ Flow Rate _____ l/min LTOT Y ❒ N ❒ Flow Rate _____ l/min

Chest diagnosis:

Past medical history:

Transport required **Y** □ **N** □ **Why?**

Referrer's name: _____Date: _____/_____/_____

Designation_____ Phone number _____

Jan 2018