GP / AHP Referral Form

The form should only take about 5 minutes. Please tick the option below:

Please complete: *

I am a GP/ health professional Dr/Prof_____

If you are making the referral on behalf of someone else:

Your name: _____Role: _____

Contact details: _____

Patient Profile

NHS number: _____

Given Name/ Forename: _____Family Name/ Surname: _____

Date of birth: _____

Address Line 1: *_____Address Line 2 _____

Town/City:*_____County*_____Postcode:*_____

▪ Contact phone number_____

Emergency contact details: ▪

Patient has difficulty to read and write in English? * Yes/No/Unknown

Patient is a registered carer for someone else? * Yes/No/Not Stated

Previously completed Pulmonary rehabilitation* Yes/No

Provider details:

Previously completed any counselling/psychotherapy interventions* Yes/No

Provider details:

Does the patient meet all the following inclusion criteria? (Please tick to confirm)

• Confirmed medical diagnosis of chronic respiratory condition (COPD, ILD, Chronic Asthma, Bronchiectasis)

or Pre/Post Thoracic Surgery

• Optimised medical therapy for respiratory and mental health conditions as per NICE guidelines.

• If smoking, consent to initiatives to reduce or quit smoking

• If on long term oxygen therapy, ambulatory oxygen must be prescribed.

• Priority will be given to those with an FEV < 50% of predicted value, CAT score 20 and above, MMRC- 3 with 1 hospitalisation > 2 weeks per 6 months (MRC 2 accepted if symptomatic and disabled by their condition)

• Priority will be given to people who have not already completed a course of pulmonary rehab.

• Informed consent to pulmonary rehabilitation and mental health therapy with an understanding that it requires motivation and active participation.

Spirometry results (please attach print out of last spirometry results)

FEV1 l/m % pred_____

FVC l/m % pred_____

FEV1/FVC %_____

DLCO % pred_____

MMRC Breathlessness Scale (please tick which applies)

0 Not troubled by breathlessness except on strenuous exercise

1 Short of breath when hurrying or walking up a slight hill

2 Walks slower than contemporaries on level ground because of breathlessness, or has to stop for breath when walking at own pace

3 Stops for breath after walking about 100 metres or after a few minutes on level ground

4 Too breathless to leave the house, or breathless when dressing or undressing

Details of symptoms (include baseline O2 levels with and without Oxygen (if prescribed)- insert small box to tick

Breathlessness:

Sputum:

Fatigue:

Pain:

Mood Swings:

Sleep apneas:

Insomnia:

Other-:

Date of symptom onset_____

▪ Current 0_2 Sats at rest (if known) _____

Prescribed with short burst oxygen / long term oxygen therapy(LTOT)/ Exercise Oxygen

L/min_____ Hrs/day_____

Prescribed with BiPAP/CPAP: _____ Date Prescribed_____

Have completed any exercise endurance test previously ▪ Yes/no

If so, please tick:

Sit-to-stand test/6 Min walk test/ Incremental Shuttle Walk test/Endurance Shuttle Walk test

Date of last test _____ Distance Walked_____Km/M

Lowest O_2 Sat's during one-minute: _____

Medications (include O2 prescription): _____

Other significant information

Patient lives alone * Yes /No

Patient lives in apartment/ house/ bungalow?

Patient Smoke/ Chew tobacco: Yes/No?

If yes for smoking, specify the type: Cigarettes, cigars, bidis, kreteks, pipe or hookah

No of cigarettes per day_____ No of Years_____

Patient drink alcohol * Yes/ No

If yes, how many bottles/ glasses/week_____?

Patient have any mental health issues * Yes / No?

_____

▪ COVID-19 test result, if available or date test appointment_____

Where did you hear about the service? _____

▪ Consent to share

I understand that the information I provide will be stored securely as a part of patient medical record in Tele-Therapies. If required any part of information provided in the referral will be shared with relevant medical/ healthcare professionals for purpose of care management with best interest of patient health and quality of life care and improvement.

Yes/No

Thank you for completing the referral. Please give us 48 hours to respond. Thanks in advance for your patience.

Official Service use (please leave blank):

Date received:

Triage: A/B/C/D **Date of 1st consultation date:**

Signature:

Emergency contact details: ▪ Carer/Friend/Family-name and contact phone number