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| **Area**  | **Send referral to**  | **Telephone**  |
| [ ]  Bognor, Littlehampton​, Sompting [ ]  Horsham, Crawley, Mid Sussex | **Sussex Community NHS Foundation Trust**Sc-tr.OneCallWSReferrals@nhs.net | 0300 37 37 111 |
| ​​☐​ Chichester  | **University Hospitals Sussex NHS Foundation Trust**uhsussex.pulmonaryrehab@nhs.net   | 01243 788122 Ext. 35184  |
| *To refer to a different Trust, please contact the respective CCG for the correct referral form*  |

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| **Referral Criteria** |
| [ ] **Routine**  | Patient would benefit from a 12-session exercise and education programme (patient will be assessed and enrolled within 12 weeks) |
| [ ] **Fast Track**  | Following recent hospital admission due to COPD (patient will be assessed and enrolled within 4 weeks)  |
| **INCLUSION criteria**: The patient must meet **ALL** of:* Breathlessness that limits functional ability, secondary to a respiratory cause i.e. COPD, stable asthma, bronchiectasis, interstitial lung disease
* MRC grade 3 or above (MRC 2 accepted if symptomatic and disabled by condition)
* Able to follow simple commands
* On optimal respiratory medication
* Any other medical conditions to be optimally treated and stable.
* Consents to engaging with the service- able to commit to a 6-week programme of moderate to high intensity exercise, and self-help twice a week.
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| **EXCLUSION criteria**: Pulmonary Rehabilitation is **NOT** appropriate if the patient has significant co-morbidities that render them unable or unsafe to exercise strenuously e.g.* Long Covid symptoms (refer to sc-tr.covidrehabilitation@nhs.net)
* Breathlessness as a result of a non-respiratory related cause e.g., anaemia
* Uncontrolled hypertension (BP>170/100)
* Unstable cardiovascular disease e.g. cardiac arrhythmias, unstable angina, severe aortic stenosis
* Recent cardiac event (e.g. MI in last 6 weeks)
* Untreated / Uncontrolled Diabetes or Epilepsy
* History of spontaneous Pneumothorax within the last 3 months
* Any other conditions precluding moderate intensity exercise e.g., severe arthritis, peripheral vascular disease, chronic pain
* Any psychiatric, cognitive or locomotor problems that would prevent safe participation in exercise or in a group setting.
* Patients with a BMI <18 must have had or be having current input from dietician before consideration for PR. Please also consider for high BMI.
* Has completed pulmonary rehabilitation within the last 12 months and not had a respiratory related hospital admission
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| **Patient Demographics** | **GP Practice Details** |
| Surname |  | GP Name GP PracticeGP PhoneGP Email |
| First names |  |
| DOB |  | Title |  |
| NHS No. |  | BMI | [VALUE] |
| Address |   |
| Phone No |  |
| Email |   |

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| **Supporting Patient Information** | **Yes** | **No** |
| Has consent been gained from the patient to be referred into, and for information to be shared with, the respiratory team? |[ ]  [ ] \* |
| Has consent been gained from the patient to share information out of the Respiratory Team with other healthcare services, if required? |[ ]  [ ]  |
| Are there any known risks regarding lone working or any history of antisocial behaviour displayed? **If yes, please give details:**  | [ ] \* | [ ]  |
| Is the patient cardio vascularly stable? (See exclusion criteria) |[ ]  [ ] \* |
| Does the patient need an interpreter or accessibility adaptations? **If yes give details:** | [ ]  |[ ]
| \* Unlikely to be accepted or suitable for the service, seek advice before referral. |
| **Reason for Referral** |
| Please note that without the following confirmation, the patient may not be accepted onto the service.**Primary Respiratory Diagnosis****Date of diagnosis:** [ ]  **COPD** (Please provide spirometry incl. trace and full report\*) [ ]  Spirometry data completed below\* [ ]  Spirometry trace attached\*[ ]  **Asthma** (Please provide diagnostic spirometry with reversibility incl. trace and full report\*) Formal diagnosis? [ ]  Yes [ ]  NoPlease ensure the patient’s asthma is stable, not exercise induced and the patient must be functionally limited by their asthma rather than any other comorbidities.  [ ]  Spirometry data completed below\* [ ]  Spirometry trace attached\*[ ]  **Bronchiectasis** (Please provide HRCT report) [ ]  HRCT report attached[ ]  **Interstitial lung disease** (Please provide HRCT or MDT consensus) [ ]  HRCT report attached [ ]  MDT consensus letter attached |
| **Spirometry Results:** (Mandatory for referrals for asthma or COPD, also attach a spirometry trace**\***)**\***FEV1% predicted: [FIELD] **\***FEV1/FVC ratio: [FIELD] **\***FEV1/VC ratio: [FIELD] **\*** Referral is likely to be rejected if these are not included. |
| **Please give a brief description of the reason for the referral:** |

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| **Oxygen Status**Last recorded SpO2 on air: [FIELD]Last recorded SpO2 on oxygen: [FIELD]  Oxygen lpm:-  **Current user of home oxygen?:** [ ]  No [ ]  YesDetails: [ ]  Long-term [ ]  Ambulatory [ ]  Palliative How many litres/min / FiO2:  Hours of usage per day:  |
| **Other Risks**Does the patient have a known abdominal aortic aneurysm (AAA)? [ ]  No [ ]  Yes #*# If the patient has an Abdominal aortic aneurysm (AAA) please provide a CT scan, ultrasound or MRI angiography report. (Patients with a AAA >5.5cm may not be suitable for PR and we will require vascular reassurance before proceeding and may also require considerable exercise adaptation)*Supporting AAA evidence attached [ ]  Yes  |
| **Supporting Evidence** | **Yes** | **No** |
| Supporting diagnosis evidence attached |[ ]  [ ] **\*** |
| GP Summary attached |[ ]  [ ] **\*** |
| Medication summary attached |[ ]  [ ] **\*** |
| **\* Without this supporting information, your referral may be rejected**  |
| **Referred By** |
| Name:  | Role: |
| Contact Details: | Date: |