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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](mailto: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. | | | | | | |
| **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](mailto: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 | | | | | | |
| **Patient Demographics** | | | | | | **GP Practice Details** |
| Surname |  | | | | GP Name  GP Practice  GP Phone  GP 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  No  Please 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  Yes  Details:  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: | | |