Health Service LOGO ***Pulmonary Rehabilitation Referral***

Date of Referral: ***Consultant:***

Name ***DOB*** ***MRN***

Address: ***Phone Number:***

Diagnosis:

Lung Function Date:

FEV1 > 80%	GOLD I - Mild	
FEV1 > 50% - <80%	GOLD II - Moderate	
FEV1 >30% - < 50%	GOLD III - Severe	
FEV1 < 30%	GOLD IV - Very severe	

Inclusion Criteria (Please Tick) ?

1.Dx chronic respiratory disease (e.g COPD, bronchiectasis, lung transplant candidates)	
2. No evidence of unstable asthma, ischaemic heart disease, decompensate/unstable heart failure, severe or uncontrolled systemic arterial hypertension, neuromuscular or musculoskeletal disorders or other disabling diseases that could resist exercise training.	
3. No suspected underlying malignancy	
4. Motivated to attend a 8 week outpatient exercise and education programme in a group setting.	
5. Has the ability to exercise independently with supervision.	

Relevant Investigations.
CXR_____
ABG _____
ECG _____
ECHO EF_____% PAP's_____mmHg
Other

Optimization of respiratory medication per ITS/ICGP guidelines ☐ Yes ☐ No.
Please List medications :

Have you discussed pulmonary rehabilitation with patient? ☐ Yes ☐ No

Will transport be required? ☐ Yes ☐ No

Smoking status: ☐ Current Smoker ☐ Ex-smoker (≥12mths) ☐ Never Smoked

If smoker has patient been referred to Smoking Cessation Officer ☐ Yes ☐ No

LTOT: ☐ Yes ☐ No _____L 16 / 24 hr/day Portable Oxygen ☐ Yes ☐ No ____L

Referring Health Professional

Name: _____ **Signature:** _____

Phone: _____ **Fax:** _____ **Email:** _____