PULMONARY REHABILITATION REFERRAL

Use SCI Gateway Form unless the Gateway unavailable

NHS Greater Glasgow and Clyde

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 Fax Number 0141 211 3396

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.**

Interpreter required **Y**□ **N**□ If Yes, then which language_____

Inclusion Criteria – ALL REQUIRED
(Please tick all that apply)

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

Exclusion Criteria
(Please tick any that apply)

- ❒ **Successful Completion** of pulmonary rehabilitation programme within the past 2 years (Refer for Maintenance below)
- ❒ 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 assessment and referred to maintenance exercise class if appropriate]

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

MRC Score (must be 3 or greater) – **circle as appropriate**
Grade 1. Not restricted in usual daily activity
Grade 2. Copes with daily activity but some difficulty keeping up with peers – especially hills and stairs
Grade 3. Restricted activity out-of-doors – unable to keep up with peers on the level
Grade 4. Marked limitation in outdoor activity – stairs and inclines with great difficulty. Self caring indoors
Grade 5. Essentially housebound and requires some assistance in personal care

Patient's respiratory 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 if not COPD: (hospital use only)

Relevant past medical history:

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

Designation_____ Phone number _____

Preferred site for assessment WIG □ GRI □ Stobhill □ SGH □ Victoria □ RAH □ IRH □ VoL □ Easterhouse HC □
Preferred site will be offered unless (unusually) waiting time guarantee cannot be met