***INTERIM* COMMUNITY PULMONARY REHABILITATION REFERRAL FORM**

**Please enclose an up-to-date medication list and full completion of differential tests otherwise the referral will not be accepted and returned to referrer.**

**Exclusion criteria:**

Severe or unstable cardiovascular disease including recent MI in the past year, advanced dementia and anaemia. Mobility issues that would prevent a patient from participating from an intense physical exercise programme or other significant disease that precludes participation in an exercise programme. **If in doubt please query with the relevant team (Team contacts detailed page 3).**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Patient details**  DOB: | | | Title: | **GP details**  Name:  Address:  Postcode:  Tel: | |
| Surname:  Forename:  Address:  Postcode:  Tel:  NHS number:  Hospital number: | | | |
| **Comorbidities:** | |
| **Presumed Respiratory Diagnosis:** | | | |
| **Have the following tests been completed to rule out the differential:**  CXR – box to tick – attach result to referral  FBC – box to tick - attach result to referral  BNP – box to tick – attach to referral  Serial Peak flow (not mandated part of this proforma)– box to tick – attach to referral   * If peak flow not included – why.   BMI: box to write in value  HR BP O2 saturations at rest  Last sputum sample if done | | | | | |
| **Does the referrer have a process set up to review patients who have been referred to pulmonary rehab without a formal spirometry diagnosis? Yes No**  ***If no the referral will be returned until this process is in place.***  The PR provider has the right to contact periodically to check on this process and where safe request for the completion of spirometry should the diagnosis be in question. | | | | | |
| **MRC Grade** (please select appropriate grade) | | | | | |
| 1  2  3  4  5 | * Not troubled by breathless except on strenuous exercise * Short of breath when hurrying on a level or when walking up a slight hill * Walks slower than most people on the level, stops after a mile or so, or stops after 15 minutes walking at own pace * Stops for breath after walking 100 yards, or after a few minutes on level ground * Too breathless to leave the house, or breathless when dressing/undressing | | | | |
|  | |  | | |  |
| **Medication**  Please enclose a copy of the patients medication- enclosed : Yes/No | | | | | |
| **Consent**  Patient consents and is committed to attending twice weekly for 6 weeks PR sessions: Yes/No | | | | | |
| **Please give details of any patient specific issues e.g. language/oxygen/transport:** | | | | | |
| **Referrer details**  Referring organisation:Referrer role:  Referrer Contact Number: **Print name:** | | | | | |
| **FOR OFFICE USE ONLY: Date Received: Post Exacerbation/Stable** | | | | | |

\*Referrers responsibility to explain to the patient that PR may be ceased at any point if it is felt that the diagnosis is incorrect.

\*\* This is an interim proforma, created due to Covid. The referral criteria will be continually reviewed in alignment with any Spirometry instruction changes.

Pulmonary Rehabilitation (PR) has been shown to be most effective therapeutic intervention in COPD and should be offered to patients with a view to improving shortness of breath, health status and exercise tolerance.

A diagnosis of COPD relies on a comprehensive history and confirmation of fixed airflow obstruction without reversibility on Spirometry.

**Symptoms**

Suspect a diagnosis of COPD in people over 35 who have a risk factor (generally smoking or a history of smoking) and who present with 1 or more of the following symptoms:

* exertional breathlessness
* chronic cough
* regular sputum production
* frequent winter ‘bronchitis’
* wheeze.

**Consider Differential Diagnosis COPD v Asthma**

|  |  |  |
| --- | --- | --- |
|  | COPD | Asthma |
| Smoker or ex-smoker | Nearly all | Possibly |
| Symptoms under age 35 | Rare | Often |
| Chronic productive cough | Common | Uncommon |
| Breathlessness | Persistent and progressive | Variable |
| Night time waking with breathlessness and/or wheeze | Uncommon | Common |
| Significant diurnal or day-to-day variability of symptoms | Uncommon | Common |

**PEFR**

In the absence of spirometry, obstruction can also be identified using peak expiratory flow rate. PEFR is reduced in obstruction and in COPD PEFR does not vary.

* PEFR <80% predicted suggests a degree of airflow obstruction and will detect >90% of cases of COPD and 100% of GOLD stage 3 and 4.**A normal peak flow rules out COPD.**
* When trying to assess for COPD, a serial measurement over 2 weeks that does not vary but also remains low despite use of salbutamol for symptom relief would suggest fixed airflow obstruction and is suspicious for COPD in the context of supporting clinical history.
* Patients who do not have variation in peak flow should have an empirical trial of dual bronchodilator therapy.
* 10% of patients with emphysema can present with normal PEFR and spirometry therefore use clinical judgement for onward referral if required.

All queries should be directed to the relevant Pulmonary Rehabilitation Service:

**Nottingham North &East** 0300 083 01 00 **Rushcliffe** 0115 8440504

**Nottingham West** 0115 8834182 **Nottingham City** 0115 883 36 22

**Mid Notts** 01623 781899

Referrals should be sent to the relevant service via secure email to:

**Nottingham N&E;** [SouthNottsCommunityHUB@nottshc.nhs.uk](mailto:SouthNottsCommunityHUB@nottshc.nhs.uk)

**Rushcliffe**; [cardio.rushcliffe@nhs.net](mailto:cardio.rushcliffe@nhs.net)

**Nottingham West**; [Pics.picsreferrals@nhs.net](mailto:Pics.picsreferrals@nhs.net)

**Nottingham City**; [ncp.respiratory@nhs.net](mailto:ncp.respiratory@nhs.net)

**MidNotts**; [MidNottsPR@Nottshc.nhs.uk](mailto:MidNottsPR@Nottshc.nhs.uk)