Community Intervention Service
Pulmonary Rehabilitation
Referral Form

Date of referral:

Thank you for referring your patient to Pulmonary Rehabilitation provided by Suffolk Community Services.

Criteria for referral to Pulmonary Rehabilitation

The patient must have the following:	**The following conditions will exclude someone from a rehabilitation programme:**
Confirmed diagnosis of COPD which is being optimally treated	Severe musculoskeletal conditions MI within last 6 weeks Uncontrolled hypertension Unstable angina Acute LVF Uncontrolled cardiac arrhythmias Aortic stenosis Uncontrolled diabetes

Patient Name	**Next of Kin** (Relationship)
NHS No. **CRN No.**	**Work Tel No.** **Home Tel No.**
Home Address **Postcode** **Tel No**	**Preferred Contact** (Carer/Neighbour etc)
D.O.B **Sex M** ☐ **F** ☐	**Work Tel No.** **Home Tel No.**
GP Details:	

Relevant Medical History/co-morbidities:

Does the patient have a frailty score known? Y ☐ **N** ☐
If yes please specify (mild, moderate, severe or Rockwood score 1-9):

Date spirometry performed:	**FEV_1:**	**FVC:**	**FEV_1/FVC:**	**SpO_2**	☐ on air ☐ on LO 2

Current Medication (FP10 may be attached)

Oxygen therapy	
No	☐
LTOT	☐
SBOT	☐
AO	☐

Exercise tolerance:

Additional information: Signer/interpreter required (please specify):

Person referring: **Position:**
Contact details:

Tel no:

Please return this form via email to: suffolk.ccc@esneft.nhs.uk
Care Co-ordination Centre, Constantine House, Constantine Road, Ipswich, IP1 2DH