DNACPR	Yes / No (please circle)

Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

IMPORTANT: Fax this form to 0151 600 1728 or email breathe.lhch@nhs.net on the same day the patient is seen in the Practice or Clinic

Pulmonary Rehabilitation Referral – Post COVID 19 form

Referral Date: ……..

Referrer: ***(Please tick ☑ as appropriate)*** GP ☐ Consultant ☐ Practice ☐ Community ☐ Physiotherapist ☐ Other ☐ ☐ Nurse ☐ Matron

Referrer (print name):…… …… **Designation:**……..

Referrer's contact address: ……

Signature of Referrer: …… **Referrer's Contact No:**…….....

Registrars please list your Consultant and Hospital: ……

PATIENT DETAILS:

Name: Mr/Mrs/Miss/Ms …… **DoB:** …… **NHS Number:** ……

Address: ……..

Post code ……

Patient Contact tel. no: ……..…… **Mobile no.:** ……...

GP's Name: …… **GP's tel. no**: ……

GP's Address: ……

Postcode: ……....

History of Present condition:-Diagnosis……

Current observations

HR……BP…..……Sao2…….. Rate of perceived breathlessness score at rest (0-10)……...

Target saturations 88-92% ☐ or 94%-98% ☐

Sit to Stand test results

Current Exercise Tolerance (e.g 10 metres walking)	Heart rate	Lowest sao2	
	Sao2%	Total Number of STS	
	RR	Rest period	
	RPE	Symptoms	

Mobility Status ***(Please tick ☑ the relevant category for each question)*****:**

1. How does the patient mobilise? - Independent without aid ☐ Independent with aid ☐ With supervision ☐ With assistance ☐
2. What mobility aid(s) does the patient use? – Walking stick ☐ Delta/three wheeler frame ☐ Zimmer frame ☐ Trolley/Scooter ☐
3. **Is the patients mobility back to their baseline level ?**Yes☐ No☐ **If no (please give more details below)**

Mental well being

Measure	**Total**	**Additional information**
PHQ9		
GAD7		

Past Medical History (Please tick □ if there is no past medical history)

Exclusion Criteria ***(Please tick ☑ Yes or No)***

Y	***N***	***Exclusion Criteria***
		Unstable angina
		Acute LVF
		Uncontrolled hypertension/arrhythmia
		MI within 6/52 of commencing rehab
		Compliance issues

Date of last exacerbation of COPD, if it has been in the past 6 weeks:
……

Current Medication (*Please list all medication the patient is taking*)

Oxygen at Home: Yes / No PRN/LTOT **l/min:** …… for ….. hours

Additional information:-