ST VINCENT'S HOSPITAL SYDNEY

Pulmonary Rehabilitation Referral

MRN		SURNAME	
OTHER NAMES			
DOB	SEX	AMO	WARD/CLINIC

(Please enter information or affix Patient Information Label)

ST VINCENT'S HOSPITAL PULMONARY REHABILITATION PROGRAM

Email: SVHS.PulmRehab@svha.org.au

REFERRER DETAILS

Date:_____/_____/_____

Referrer Name: **Contact number:**

☐ Respiratory Physician ☐ Cardiologist ☐ General Practitioner ☐ Physiotherapist ☐ Nurse ☐ Self

☐ Other: *(please specify)*_____

REQUESTED SERVICES

☐ Exercise Rehabilitation ☐ Nutritional Management ☐ Pulmonary Rehabilitation Physician Review ☐ Occupational Therapy

☐ Airway clearance ☐ Disease specific education ☐ Psychological Management

Please provide details / reasons for referral:_____

INCLUSION CRITERIA

☐ Confirmed chronic respiratory disease

☐ Patient is aware of and has consented to referral

EXCLUSION CRITERIA

☐ New York Heart Association Failure Class IV (Severe Chronic Heart Failure), symptomatic at rest.

☐ Symptomatic cardiac disease and/or has undergone a cardiac procedure within the last 8 weeks.

☐ Any musculoskeletal, neurological, psychological or cognitive impairment which would preclude ability to exercise in a group setting.

☐ Being confined to a wheelchair.

☐ Already completed a Pulmonary Rehabilitation Program, or an equivalent, in the last 12 months (unless significant change in chronic respiratory disease).

TREATING GP

Name: **Contact number:**

Address:

TREATING RESPIRATORY PHYSICIAN *(if applicable)*

Name: **Contact number:**

Address:

PULMONARY REHABILITATION REFERRAL

P110

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RESPIRATORY CONDITIONS

☐ COPD ☐ Asthma ☐ Bronchiectasis ☐ ILD ☐ Pulmonary Hypertension

☐ Pre/Post lung surgery: *(please provide date and details)*_____

_____

_____

_____

LATEST SPIROMETRY RESULTS

Date:_____/_____/_____

FEV1: Measured (L) _____ Predicted (%) _____

FVC: Measured (L) _____ Predicted (%) _____

FEV1/FVC _____

Is this patient prescribed home O2: ☐ Yes ☐ No If so, _____L/Min _____Hrs/day

Medical Officer Use Only:

Do you agree to the use of an appropriate level of supplemental oxygen if the patient desaturates during the exercise?

☐ Yes ☐ No

Target level of SpO_2 during exercise:_____

OTHER PAST MEDICAL HISTORY	SOCIAL HISTORY

PLEASE ATTACH THE FOLLOWING WITH YOUR REFERRAL

☐ A recent health care summary ☐ Most recent discharge summary ☐ Medication list and relevant investigations

Does this patient have a history of aggression / violence / psychiatric history:	☐ Yes ☐ No
Does this patient require an interpreter? Language:	☐ Yes ☐ No
Does this patient require assistance with transport:	☐ Yes ☐ No
Does this patient identify as Aboriginal or Torres Strait Islander:	☐ Yes ☐ No

NO WRITING