MidCentral District Health Board
Te Pae Hauora o Ruahine o Tararua

REFERRAL FORM FOR CONSIDERATION OF PULMONARY REHABILITATION PROGRAMME OR UCOL UKINETICS PROGRAMME

STOP - CONSIDER BEFORE REFERRAL:

1. If patient has mild COPD – **refer** to Green Prescription or PAE (CPHO)
2. Assess for breathing dysfunction:
3. Moderate to severe COPD (FEV_1: ≤65% / Ratio: ≤75% / Perceived breathlessness) - Proceed onto referral form

Breathing Dysfunction Assessment

- ☐ Upper chest breathing and mouth breather
- ☐ Becomes breathless on anticipated activity (see node 15 of 'Management of Stable COPD' Pathway)

PATIENT INFORMATION

Name: _____ **NHI #:** _____ **DOB:** _____ **Gender:** _____

Phone #: _____ **Ethnicity:** _____

Address: _____

_____

Referrer/Designation: _____ **Date Referred:** _____

Respiratory Diagnosis: _____

_____

Smoking History: **Current** ☐ **Ex-smoker** ☐ **Pack year history:** _____

Co-morbidities: _____

_____

Motivation/commitment level to attend: _____

Investigation		Date of Test	Results	
Spirometry (Resp Services Referral Form)	(**pre** bronchodilator)		FEV_1: . L (%)	FEV_1/FVC: %
	(**post** bronchodilator)		FEV_1: . L (%)	% Change: %

Attach the following to the referral form:	
CXR Report	
ECG (MDHB ECG Request Form)	
FBC	

Investigation	Results	Date Taken	Investigation	Results	Date Taken
MMRC:			Blood Pressure:		
CAT Score:			Respiratory Rate:		
BMI:			$Sp0_2$ room air resting (5-10 mins):		
Weight:			Heart Rate:		
Lipids:			Breathing Pattern:		
Glucose:					

HISTORY

Inhaled Medications:

Name	Dose	Frequency Taken

Adherence

Takes inhalers every day as prescribed: **YES** ☐ **NO** ☐

How many times a week do you forget to take your inhaler/s? _____

Technique

Technique for taking inhalers is correct: **YES** ☐ **NO** ☐

Poor technique now corrected: **YES** ☐ **NO** ☐

Takes inhalers via *(tick most appropriate)*:

- Spacer ☐
- Accuhaler ☐
- Turbuhaler ☐
- Handihaler ☐

OTHER MEDICATIONS

Please list other medications patient is taking:

_____

_____

_____

_____

BARRIERS THAT MAY IMPACT ON ADHERENCE OR ATTENDANCE

Transport: **YES** ☐ **NO** ☐

Not contactable: **YES** ☐ **NO** ☐

Other *(state)*: _____

_____

Issues Resolved: **YES** ☐ **NO** ☐

Is this patient clinically stable at time of referral: **YES** ☐ **NO** ☐

PLAN/ACTION FROM MCH TEAM

_____

_____

_____

_____

_____

_____

_____

_____

_____

DATE DISCUSSED: _____

Email completed referral form to: respiratory.services@midcentraldhb.govt.nz or fax to: (06) 350 8647