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| **Breathe Better for Life Remote Pulmonary Rehabilitation Course Referral Form** |
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| **What is Breathe Better for Life?** |
| * What is it? An evidence based exercise and education programme for people with long term respiratory conditions, including but not exclusively COPD.
* Aims: 1. to increase fitness, exercise tolerance and motivation to be physically active

 2. to teach self-management of condition and symptoms particularly breathlessness  3. to improve quality of life and independence with activities of daily life* Requirements: participants will need to commit to completing a prescribed home exercise programme over a six week period, including aerobic activity and strength training.
* Delivery: The programme has been adapted to be delivered in a safe way remotely. Depending on their technological capability, participants may register for either online education and exercise videos or written personalised exercise and education booklets. All participants will benefit from multi- disciplinary professional support during the programme.
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| **Risk of Remote Delivery** |
| * Due to the COVID-19 pandemic the British Thoracic Society have advised that remote delivery is the safest option for all PR programmes at present.
* Subsequently, most participants will only be assessed via telephone /video consultation, therefore a higher level of disease stability is required to ensure safety to exercise.
* It is therefore both the referrers and assessors responsibility to ensure participants are suitable for the programme.
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| **Inclusion Criteria**  |
| * Confirmed diagnosis of a respiratory condition (or post COVID).
* MRC score between 2 and 4 (inclusive).
* Motivated to complete home programme with distant supervision only.
* Current medical management optimised, including inhaled therapies.
* If on long term oxygen therapy then ambulatory oxygen should be prescribed.
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| **Exclusion Criteria**  |
| * Unstable coronary or cerebral ischemia or inability to independently manage changes in symptoms / disease status.
* Unstable diabetic control or inability to independently manage changes in symptoms/ disease status.
* Within 10 days of starting treatment for deep vein thrombosis or pulmonary embolism.
* Within 6 weeks of acute myocardial damage e.g raised troponin or NSTEMI.
* Unstable medical conditions: e.g decompensated heart failure, recent aortic dissection, uncontrolled and malignant hypertension, active gastrointestinal bleeding or severe anaemia.
* Medical falls or frequent mechanical falls.
* Significant active exacerbation/ infection or in early recovery phase (1 month)
* Moderate cognitive deficit (unless adequately supported by a carer).
* The inability to exercise due significant musculoskeletal or neuromuscular disorders.
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| **Patient Details**  |
| **Name** |  | **Address & Postcode** |  |
| **NHS** |  | **DOB** |  |
| **Telephone number(s)** |  | **GP Practice/ Respiratory Consultant** |  |
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| **Clinical Detail** |
| **Diagnosis** |  |
| **HPC including admissions/ exacerbations** | (incl. dates) |
| **PMH** |  |
| **Medications**  |  |
| **Investigations** | Recent CXR findings:Date: |
| **Spirometry** | Date: | Value  | % Predicted | Reversibility to bronchodilator? Yes [ ] /No [ ] (BTS improvement of 200ml %15% FEV1) |
|  | FEV1 |  |  |
|  | FVC |  |  |
|  | FEV1/FVC ratio |   |  |
| **Oxygen Therapy**  | Yes [ ] /No [ ]  Details= |
| **Vital Signs** | (Please include the most recent measurements possible) BP: Date: Usual /target saturation range:  |
| **BMI** |  Date:  |
| **Smoking Status** | Never/ Ex / Current |
| **MRC Dyspnoea Scale (tick one)** |
| [ ]  1— Not troubled by breathless except on strenuous exercise |
| [ ]  2-- Short of breath when hurrying on a level or when walking up a slight hill |
| [ ]  3-- Walks slower than most people on the level, stops after a mile or so, or stops after 15 minutes walking at own pace |
| [ ]  4-- Stops for breath after walking 100 yards, or after a few minutes on level ground |
| [ ]  5-- Too breathless to leave the house or breathless when dressing or undressing. |
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| **Referrer Details and Declaration** |
| I confirm this patient has consented to the referral, has **no** exclusion criteria and meets **all** inclusion criteria. *Please note incomplete forms will not be returned.* |
| **Name** |  | **Designation** |  |
| **Location** | (practice/hospital) | **Date** |  |
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| **Email to:** **cft.westcornwallrespiratory@nhs.net** |
| The West Cornwall Community Respiratory Service, Helston Community Hospital, TR13 8D  |
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