

Date of Referral: _____

Consultant: _____

Name _____

DOB _____

MRN _____

Address: _____

Phone Number: _____

Diagnosis:	Lung Function	Date:	
	FEV1 > 80%	GOLD I - Mild	
	FEV1 > 50% - <80%	GOLD II - Moderate	
	FEV1 >30% - < 50%	GOLD III - Severe	
	FEV1 < 30%	GOLD IV - Very severe	

Inclusion Criteria (Please Tick) ✓

1. Dx chronic respiratory disease (e.g COPD, bronchiectasis, lung transplant candidates)	
2. No evidence of unstable asthma, ischaemic heart disease, decompensate/unstable heart failure, severe or uncontrolled systemic arterial hypertension, neuromuscular or musculoskeletal disorders or other disabling diseases that could resist exercise training.	
3. No suspected underlying malignancy	
4. Motivated to attend a 8 week outpatient exercise and education programme in a group setting.	
5. Has the ability to exercise independently with supervision.	

Relevant Investigations.

CXR _____
 ABG _____
 ECG _____
 ECHO EF _____% PAP's _____mmHg
 Other _____

Optimization of respiratory medication per ITS/ICGP guidelines Yes No.
 Please List medications :

Have you discussed pulmonary rehabilitation with patient? Yes No

Will transport be required? Yes No

Smoking status: Current Smoker Ex-smoker (≥12mths) Never Smoked

If smoker has patient been referred to Smoking Cessation Officer Yes No

LTOT: Yes No _____L 16 / 24 hr/day Portable Oxygen Yes No _____L

Referring Health Professional

Name: _____

Signature: _____

Phone: _____

Fax: _____

Email: _____