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| **Post COVID-19 Admission** **Pulmonary Rehabilitation** **Referral Form*****(Complete form & email)*** | Respiratory DepartmentLevel 3 Salisbury District HospitalSalisburyWiltshireSP2 8BJ*Tel 01722 336262 Ext 2892**PULMONARYREHAB*  *sft.pulmonaryrehab@nhs.net* |

**Patient Details:**

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| Hospital no. |       | NHS no. |       |
| Surname |       | Forenames |       |
| Previous surname |       | Title |       | Sex |       |
| Date of birth |       |  |  |
| AddressPost Code |            | **Home tel. no.** |       |
| **Work tel. no.** |       |
| **Mobile no.** |       |

**Referral Details:**

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| Referring clinician |       | COVID19 pamphlet  | Y: 🞎 N: 🞎 |
| GP Practice/ Department |       | Resp Nurse Teleclinic date  |       |
| Date of referral |       | Chest Radiograph requested  | Y: 🞎 N: 🞎 |

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| **History of COVID-19 episode (including date of onset symptoms/date of discharge):****Current mobility:****Timed up and go (physio):****Oxygen requirement on discharge:****Non- Invasive Ventilation/CPAP:****DHx:**      **PMHx:****SHx:** **Any obvious contraindications to exercising at home:**  |

**Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Designation:-------------------------- Date \_\_\_\_\_\_\_\_**