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| **Post COVID-19 Admission**  **Pulmonary Rehabilitation**  **Referral Form**  ***(Complete form & email)*** | Respiratory Department  Level 3 Salisbury District Hospital  Salisbury  Wiltshire  SP2 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 |  |  |  | | |
| Address  Post 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 \_\_\_\_\_\_\_\_**