

**CHRONIC RESPIRATORY SUPPORT Programme**  
**CRS Team**

***REFERRAL FORM***

(Please refer to the criteria on the reverse when completing this form)

**Patients Name:**..... **Hospital Number:**.....

**Address:**..... **Date of birth:**.....

..... **Phone No:**.....

.....  
**Diagnosis for this admission:**

**Changes in health care needs since admission:** (e.g. LTOT, Nebuliser)

**MRC:**.....(Has this patient been considered for Pulmonary Rehabilitation?)

**MMSE:** .....(on all patients over 65 years or for concerns about cognition)

**Smoking status:**.....

**Previous medical history:**

**What minimum O2 saturation do you accept as normal for this patient when well?**

**Do you require the patient to attend a f/u medical appointment.** Yes / No  
(If yes, this appointment must be arranged as per your normal practice)

**Do you require a follow up xray / other investigation for this patient.** Yes / No

Appropriate forms completed? Yes / No

**Referred by:** Print:..... Signature:.....

Consultant Respiratory Physician responsible for the patient:.....  
*Date of referral:*.....

*To be completed by REDS Team*

**Accepted / Not accepted by REDS team** Signature.....

Date of acceptance:..... Reason for not accepting patient onto scheme:.....

Referrer informed of outcome: Yes / No Date:.....

**Key Worker: Name**.....

*1 copy for REDS team, 1 copy to be placed in patients notes.*

## **Criteria for inclusion in Chronic Respiratory Support Programme (CRS)**

### **The aim of the service is :**

- To provide personalised respiratory support to a targeted group of patients in their home environment for a definite period of time enabling them to improve their self management.
- To reduce re-admissions and length of stay through support and empowerment.
- To encourage Pulmonary Rehabilitation / exercise at home.
- To attend urgent calls for help with managing deteriorations in the patients respiratory condition while in the community.
- To provide encouragement & support for self management as patients ability safely allows
- To refer to outside agencies for additional support deemed necessary to enable the patient to manage at home.

### **The patient must:**

- Live in Islington or Haringey. Residents from other boroughs will be considered on an individual basis.
- Have a primary chronic diagnosis of moderate to severe COPD, Bronchiectasis, Pulmonary Fibrosis, Type 2 Respiratory Failure, Pneumonia on a background of definite diagnosis of COPD / Bronchiectasis with an MRC of 3 or above.
- May have asthma on a background of definite diagnosis of COPD
- May have co-morbidities but long term respiratory must be primary diagnosis and cause of breathlessness. Where chronic anxiety is a dominant factor this should be addressed prior to referral to CRS.
- May be 1<sup>st</sup> admission to hospital if
  - the patient declines or is not appropriate for Pulmonary Rehabilitation
  - the patient has completed Pulmonary Rehabilitation within the last year
  - Appropriate for Pulmonary Rehabilitation with FEV1 < 1 litre and patient requires supported discharge at the discretion of the Respiratory Drs / Nurses and CRS Team
  - 2 or more admissions within one year
- Be referred on the recommendations of a Consultant Respiratory Physician.
- Have stable or improving medical status when referred.
- Must have MMSE of at least 24 (to be completed by referrer on all pts. of 65 years or over or where there are concerns about cognition) unless there is a live in partner who is cognitively unimpaired.
- Patient must agree to the programme and have a desire to improve their self management ability.
- Must have a telephone.

### **Further Criteria for Exclusion from CRS service**

- History of being unable to co-operate with advice given.
- Previous evidence of failure to respond to our service
- If patient is suitable for Pulmonary Rehabilitation they should be routinely referred for this first.