

**LEWIS-MANNING HOSPICE**  
**BETTER BREATHING CLINIC REFERRAL FORM**  
 For patients with malignant and chronic lung conditions

**Post to:** Better Breathing Clinic, Lewis-Manning Hospice, 1 Crichel Mount Road, Poole, BH14 8LT

**Fax to:** 01202 672660

This referral form can be downloaded from the website: [www.lewis-manning.co.uk](http://www.lewis-manning.co.uk)

**Please attach copies of reports and relevant clinic letters, as LMH does not have direct access to EPR or similar electronic systems**

**1. ESSENTIAL PATIENT INFORMATION**

Patient's Name or Addressograph	Patient's Address with Post Code	Telephone Number
		Date of Birth
		Patient aware of referral Yes <input type="checkbox"/> No <input type="checkbox"/>
Hospital No:		
Next of Kin Name & relationship		Next of Kin Contact Number

**2. REFERRED BY**

Name and position	Contact number	Signature & Date

**3. COMMUNITY KEY WORKER (If different from above)**

Name and Position

**4. PATIENT'S GP AND SURGERY**

Telephone No:

GP aware of referral Yes  No

**5. OTHERS INVOLVED** (name and phone number where possible)

- Hospital Consultant(s)
- Other Professionals involved

**5. DIAGNOSIS**

Level, if known, eg. Lung cancer staging. COPD classification. For patients with COPD, we can only accept patients with severe or very severe disease

Patient Aware Yes  No   
 Relatives aware Yes  No

Date of Diagnosis

**Other underlying pathology**

**Details of relevant treatment with dates**

**Medication**

**Oxygen Use – see overleaf**

**Dates of investigations and tests with results**

<b>Reason for Referral</b>
<b>Other comments</b>

**The following information is required for the health and safety of the Patient, Lewis-Manning Staff and Volunteers, prior to a Patient attending an initial assessment at the Day Hospice**

<b>Level of Breathlessness</b>	
1	Not troubled by breathlessness except on strenuous exercise <input type="checkbox"/>
2	Short of breath when hurrying or walking up a slight hill <input type="checkbox"/>
3	Walks slower than contemporaries on the level because of breathlessness, or has to stop for breath when walking at own pace <input type="checkbox"/>
4	Stops for breath after about 100 m or after a few minutes on the level <input type="checkbox"/>
5	Too breathless to leave the house, or breathless when dressing or undressing <input type="checkbox"/>
<i>Reference: Medical Research Council dyspnoea scale for grading the degree of a patient's breathlessness</i>	

<b>Oxygen Use</b>
Does the Patient need to bring in portable oxygen?    Yes <input type="checkbox"/> No <input type="checkbox"/> (will required sufficient oxygen for up to 2 hours)
<b>Please enclose a copy of the latest HOOF Form with this referral or oxygen assessment report</b>
Details of any disability: .....
Details of walking aids used/needed: .....
Deafness <input type="checkbox"/> Visual Impairment <input type="checkbox"/> Confusion/memory problems <input type="checkbox"/> Balance problems <input type="checkbox"/> Co-ordination/spasm/paralysis <input type="checkbox"/> Pain on movement <input type="checkbox"/> Oedema <input type="checkbox"/> Anxiety <input type="checkbox"/>
Level walking distance manageable 10 metres minimum      Yes <input type="checkbox"/> No <input type="checkbox"/> Independent    Yes <input type="checkbox"/> No <input type="checkbox"/>
The clinic is on the First Floor, therefore the Patient needs to be able to manage stairs or a lift <input type="checkbox"/>