|  |  |
| --- | --- |
| **PATIENTS DETAILS (Fill in or sticker)** | **REFERRING PRACTITIONERS DETAILS** |
| Surname: |  | Name: |  |
| Forename: |  | Position: |  |
| Male / Female:  |  | Address:(Surgery stamp) |  |
| Date of Birth: |  |
| Address: |  |
|  |
|  |
|  |
| Post Code: |  | Post Code |  |
| Contact Tel: |  | Contact Tel: |  |
| Email Address: |  |  |  |
| NHS No: |  |  |  |

|  |
| --- |
| **CHAIN INCLUSION CRITERIA**  |
| ***Please tick*** | **Y** | **N** |
| Hip osteoarthritis  |  |  |

|  |
| --- |
| **CHAIN EXCLUSION CRITERIA** If yes to any of the below, patient is **NOT** suitable for CHAIN |
| ***Please tick*** | **Y** | **N** |
| Unstable angina |  |  |
| Poorly controlled heart failure |  |  |
| New or uncontrolled arrhythmias |  |  |
| Resting or uncontrolled tachycardia (RBHs > 100bpm\*) |  |  |
| Resting systolic blood pressure > 180\* |  |  |
| Resting diastolic blood pressure >100\* |  |  |
| High levels of frailty |  |  |
| Significant functional limitations |  |  |
| BMI 40 +  |  |  |
| Febrile illness (temporary) |  |  |
| *\*Blood pressure and resting heart rate will be recorded by BH Live during an assessment screening appointment.* |

|  |
| --- |
| **MEDICAL HISTORY**  |
| ***Please tick*** | **Y** | **N** |
| Previous MIs |  |  |
| Ischemic Heart Disease |  |  |
| Heart Failure |  |  |
| Any Other Heart Condition |  |  |
| Hypertension |  |  |
| Peripheral Vascular Disease |  |  |
| Previous Stroke/s |  |  |
| Previous TIAs |  |  |
| Cancer |  |  |
| Diabetes Type 1 /2 |  |  |
| COPD |  |  |
| Other Lung / Airway Condition |  |  |
| Other Joint Problems  |  |  |
| Neurological Condition |  |  |
| Mental Illness |  |  |

**AUTHORISATION:**

I can confirm that the details given are a true reflection of the patient’s medical history and medication and therefore refer this patient to the CHAIN programme.

 **Referrer (please sign): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name (print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***Please return this form to: Professor Robert Middleton, Orthopaedics Outpatient Department, The Royal Bournemouth Hospital, Castle Lane East, Bournemouth, BH7 7DW.***