



Murrumbidgee
Local Health District



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Pulmonary and Chronic Cardiac Rehabilitation (PCCR) Program referral form

Our Pulmonary and Chronic Cardiac Rehabilitation (PCCR) program is a free 8-week program designed to support an improved quality of life for people living with a chronic respiratory condition or Chronic Heart Failure (CHF) and reduce their likelihood of associated hospital admissions. In partnership with Back on Track Physiotherapy, the program offers patient-centred therapy with a focus on small group exercise and education sessions, with other services sometimes available on a case-by-case basis.

Who is eligible?

- People who are living with a chronic respiratory condition or CHF
- Located within travelling distance to the centres where the program is delivered

Some exclusion criteria applies – talk to your GP before referring to this program.

How do I refer?

You can refer yourself or a GP or other service can complete the referral. If referring yourself, consult your GP prior to completing the referral, as medical clearance is required to participate in this program.

Once completed, email the referral to pccr@marathonhealth.com.au

If you need help with the referral please call **1300 418 223**.

Form completed by:		Referral date:	
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Client details			
Legal first name:		Legal surname:	
Preferred name:	Date of Birth:	Gender:	Pronouns:
Address:		Suburb:	
Postcode:	Phone:	Email:	
Culture <input type="checkbox"/> Aboriginal <input type="checkbox"/> Torres Strait Islander <input type="checkbox"/> Other (please specify)			
Main language spoken at home <input type="checkbox"/> English <input type="checkbox"/> Other (please specify)			
Interpreter required <input type="checkbox"/> Yes <input type="checkbox"/> No			
Do you need communication assistance? <i>Including sign language, required communication devices or special interpreter needs</i>			
Emergency contact name	Emergency contact Phone:	Emergency contact relationship	



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GP or referring service details	
GP name:	GP practice
Phone:	Email:
Referrer name:	Referring service
Consent for referral provided by client <input type="checkbox"/> Yes <input type="checkbox"/> No	
Medical clearance attached from GP/Specialist. <i>(referrals will not be considered until provided)</i> <input type="checkbox"/> Yes <input type="checkbox"/> No	

Medical history	
Has the client been diagnosed with any of the following conditions (client requires at least one to be eligible):	
Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart failure – reduced injection failure <input type="checkbox"/> Yes <input type="checkbox"/> No
Chronic Bronchitis <input type="checkbox"/> Yes <input type="checkbox"/> No	Diastolic heart failure <input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart failure caused by valvular disease <input type="checkbox"/> Yes <input type="checkbox"/> No
Lung tissue disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Biventricular heart failure <input type="checkbox"/> Yes <input type="checkbox"/> No
Bronchiectasis <input type="checkbox"/> Yes <input type="checkbox"/> No	Right heart failure <input type="checkbox"/> Yes <input type="checkbox"/> No
Lung circulation disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Cardiomyopathy <input type="checkbox"/> Yes <input type="checkbox"/> No
Post-acute exacerbation of airways <input type="checkbox"/> Yes <input type="checkbox"/> No	Post-COVID syndrome <input type="checkbox"/> Yes <input type="checkbox"/> No

Other medical history – (ie. spirometry, ABG's, O2 requirements, comorbidities)
<i>Please include medical history information</i>

Cardiac and/or respiratory medications
<i>Please list and include medication information here</i>

Clients baseline observations
<i>Including altered criteria and action plan for medications such as inhalers and medications for Angina</i>



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Respiratory			
Beta Agonist	<input type="checkbox"/> Yes <input type="checkbox"/> No	LAMA	<input type="checkbox"/> Yes <input type="checkbox"/> No
ISC	<input type="checkbox"/> Yes <input type="checkbox"/> No	LABA	<input type="checkbox"/> Yes <input type="checkbox"/> No
Oral	<input type="checkbox"/> Yes <input type="checkbox"/> No	Anti-Cholinergic	<input type="checkbox"/> Yes <input type="checkbox"/> No
What is the participant's usual SpO2, on room air or supplemental O2?			
Does the client need fast acting medication to assist Angina or similar? ie. GTN Spray available to them at all times?			
Oxygen/flow rate:		Hours per day:	
Home oxygen	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Program location

Please note – referrals to this program can only be made to locations listed below.

Please select the appropriate location for this referral:

- West Wyalong** – April to June 2024
- Junee** – July to September 2024
- Leeton** – October to November 2024
- Lake Cargelligo** – February to March 2025
- Hay** – April to May 2025

Please note, dates may be subject to change and participants will be notified accordingly.

Pulmonary and Chronic Cardiac Rehabilitation Guidelines

Eligibility criteria	Exclusion criteria
<p>Include patients who:</p> <ul style="list-style-type: none"> ✓ Have Chronic Obstructive Pulmonary Disease (COPD) ✓ Emphysema ✓ Chronic bronchitis ✓ Asthma ✓ Lung tissue disease such as Interstitial Lung Disease, Idiopathic Pulmonary Fibrosis, Occupational and mine dust diseases (Pneumoconiosis, asbestosis) ✓ Bronchiectasis ✓ Lung circulation disease such as Pulmonary Hypertension ✓ Post-acute exacerbation of airway disease ✓ Post COVID syndrome ✓ Heart Failure with reduced or preserved ejection fraction ✓ Diastolic heart failure ✓ Heart failure caused by valvular disease ✓ Biventricular heart failure ✓ Right heart failure ✓ Cardiomyopathy 	<p>Excludes patients who:</p> <ul style="list-style-type: none"> X Acute respiratory disease (in the absence of exacerbation of chronic respiratory diagnosis) X Have severe cognitive impairment X Have severe psychotic disturbance X Have a relevant infectious disease X Musculoskeletal or neurological disorder that prevents exercise X Unstable cardiovascular disease (e.g. unstable angina, aortic valve disease, unstable pulmonary hypertension) X Any other unstable, uncontrolled condition X Post-Acute cardiac syndrome X Post percutaneous coronary intervention X Post cardiothoracic surgery (Coronary Artery Bypass Graft- CABGS, Valve repair/replacement) X Post insertion of pacemakers and defibrillators (1-6 weeks post op) X Any other unstable, uncontrolled condition