RESPIRATORY PHYSIOTHERAPY REFERRAL

To: Breathe Easy Kenya LTD
Location: Nairobi, Kenya
Phone/WhatsApp: +254 111 890358
Email: breatheeasykenya@gmail.com

Breathe Easy Kenya offers home-based respiratory physiotherapy. Providing evidence-based care for adults with chronic respiratory disease. Treatment is designed to improve functional capacity, symptom control, and quality of life.

REFERRING CLINICIAN DETAILS

Name:
_____

Specialty: ☐ Pulmonologist
☐ Cardiologist
☐ General Practitioner
☐ Other/Self-referral

Facility/Practice:_____

Phone: _____

Email: _____
Signature & Stamp:

_____

Date: _____

PATIENT DETAILS

Full Name:
_____
_____

Date of Birth / Age: _____
Sex: ☐ Male ☐ Female

Phone: _____

Email: _____

Physical Address:
_____

_____

Emergency Contact:
_____

Phone: _____

Thank you for partnering with us to improve respiratory health through evidence-based respiratory physiotherapy.

PRIMARY DIAGNOSIS (tick all that apply)

☐ COPD
☐ Asthma
☐ Interstitial Lung Disease (ILD)
☐ Post-TB Lung Disease
☐ Bronchiectasis
☐ Pulmonary Hypertension
☐ Post-COVID / Long COVID
☐ Pre/Post Thoracic Surgery

☐ Other:
_____

REASON FOR REFERRAL (tick all that apply)

☐ Reduced exercise tolerance
☐ Frequent chest infections/ exacerbations
☐ Difficulty clearing mucus
☐ Functional decline (reduced mobility)
☐ Education and self-management support
☐ Anxiety related breathlessness
☐ Neurological condition affecting breathing
☐ Pre-operative optimization
☐ Post-acute recovery
☐ Other:
_____

RELEVANT CLINICAL INFORMATION

Current Symptoms:

_____

_____

Smoking History: ☐ Never ☐ Former ☐ Current
Pack-years: _____

No. Recent Exacerbations (12 months): _____
Oxygen Therapy: ☐ No ☐ Yes ☐ AOT ☐ LTOT
(flow rate: _____ L/min)

Mobility Aids: ☐ None ☐ Walking stick or frame ☐ Wheelchair

Falls history: ☐ None ☐ 1-2 in last year ☐ 3+ (high risk)

COMORBIDITIES (tick all that apply)

☐ Hypertension
☐ Diabetes
☐ Heart Disease
☐ Vascular Disease
☐ Renal Failure
☐ Obesity
☐ Musculoskeletal Conditions (specify below)
☐ Anxiety / Depression

☐ Other:
_____

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INVESTIGATIONS (attach reports if available)

CXR / CT Chest findings:

_____

_____

Date:_____

ABG:

pH_____PaO2____PCO2_____BE__

Date:_____

Spirometry

Date:

FEV1%_____ FVC_____

FEV1/FVC ratio:

I confirm that the above patient has been informed about respiratory physiotherapy and consents to referral.

Referring Clinician Signature **Or** Patient signature for self-referral:

_____ **Date:** _____

FOR OFFICIAL USE ONLY

Date Received: _____ Initial Assessment Date: _____Clinician: _____

HOW TO REFER

Please email or WhatsApp this completed form with relevant reports to:

Email: breatheeasykenya@gmail.com
Phone / WhatsApp: +254 111 890358

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