

**Fatigue, Anxiety & Breathlessness (FAB) Self-Management Programme Referral**

Please email referrals to the FAB Programme Team at Birmingham Hospice to [hobs.referrals@nhs.net](mailto:hobs.referrals@nhs.net).

For further information on the programme or to discuss a referral please ask to speak to a member of the FAB Team on **0121 465 2000 for Erdington** or **0121 472 1191 for Selly Park**.

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| **Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Preferred Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex\_\_\_\_\_\_\_\_\_\_**  **D.O.B\_\_\_\_/\_\_\_/\_\_\_\_**  **NHS Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Post Code\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Telephone No:** | **Referrer’s Name**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Job Title\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**    **Work Base \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Tel No\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Fax No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Date of Referral: / /** |
| **GP Details:**  **GP Name: ----------------------------------------------------------------------------------------------------------------------------------**  **Address: ----------------------------------------------------------------------------------------------------------------------------------**  **Telephone Number: -----------------------------------------------------**  **Fax Number: ----------------------------------------------------------** | |
| **Next of Kin/Carer Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Contact Details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **Marital Status S / M / W / D**  **Ethnicity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Religion: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Language:\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Primary Diagnosis:**  **For active resuscitation: YES / NO If yes, please give details**  **Respect or DNAR Form completed: YES / NO** | |
| **Past Medical History:**  **Allergies: YES / NO If yes, please give details** | |
| **Is the patient registered on GP Palliative Care (GSF) Register? YES / NO** | |
| **Is the patient’s life expectancy greater than 12 weeks? YES / NO**  **Is the patient oxygen dependent? YES / NO If yes, please give details.**  **Does the patient have any communication difficulties? YES / NO If yes, please give details.**  **Does the patient have any mental capacity issues? YES / NO If yes, please give details.** | |
| **Reason for Referral** | |
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| **What does the patient hope to achieve from the FAB Programme?** | |
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| **Does the patient have their own transport to and from the programme? YES / NO** | |

**Inclusion criteria:**

• Moderate/severe symptoms of fatigue, anxiety and breathlessness.

• Diagnosis of a life-limiting illness (malignant or non-malignant disease).

• Able to attend two hourly sessions once a week for six weeks and participate in sessions.

• Ability to participate in chair-based activity/exercise.

• Must have own transport or be able to make own way to either Selly Park or Erdington Site.

**Patients will be screened following referral for eligibility on the programme.**