



GP exercise referral form – cardiac conditions

The below-named patient would like to take part in our community-based cardiac rehabilitation exercise classes. Please complete this form to help us understand their medical status and history so we can tailor our programme to suit their needs.

PATIENT DETAILS		REFERRER'S DETAILS	
Name:		Name:	Tel:
Home Tel:	Work Tel:	Profession:	Surgery/Dept:
Address:		Work address:	
Age:	DOB:		Postcode:
CONTRAINDICATIONS			
<input type="checkbox"/> I confirm the patient is clinically stable and without any of the following contraindications to exercise:			
<input checked="" type="checkbox"/> Unstable angina	<input checked="" type="checkbox"/> Systolic blood pressure ≥ 180 mmHg and / or diastolic blood pressure ≥ 100 mmHg		
<input checked="" type="checkbox"/> BP drop > 20 mmHg demonstrated during ETT	<input checked="" type="checkbox"/> Resting tachycardia > 100bpm		
<input checked="" type="checkbox"/> Uncontrolled atrial or ventricular arrhythmias	<input checked="" type="checkbox"/> Unstable or acute heart failure		
<input checked="" type="checkbox"/> Unstable diabetes	<input checked="" type="checkbox"/> Febrile illness		
<i>If any of the above apply please explain to the patient that they are not yet ready for referral and do not complete the rest of the form.</i>			
PATIENT CARDIAC HISTORY			
<input type="checkbox"/> No previous cardiac history Please tick those applicable below for all previous events, giving dates where possible:		Current angina <input type="checkbox"/> Y <input type="checkbox"/> N Date of onset: Details of angina: Triggers: Relieved by rest or GTN: <input type="checkbox"/> Y <input type="checkbox"/> N	
<input type="checkbox"/> STEMI: Size: Site: Date: <input type="checkbox"/> NSTEMI: Date: <input type="checkbox"/> Unstable angina: Date: <input type="checkbox"/> Stable angina: Date: <input type="checkbox"/> CABG: Date: PCI: <input type="checkbox"/> Primary <input type="checkbox"/> Elective Date: Cardiac Arrest: <input type="checkbox"/> Primary <input type="checkbox"/> Secondary Date: Valve: <input type="checkbox"/> Repair <input type="checkbox"/> Replacement Date: <input type="checkbox"/> Heart failure Date: NYHA classification: 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/>	Arrhythmias <input type="checkbox"/> Y <input type="checkbox"/> N Date of onset: Details of arrhythmias:		Devices ICD fitted: Pacemaker fitted: Details/Settings:
PATIENT MEDICATION (please tick all those currently taken)			
<input type="checkbox"/> Aspirin <input type="checkbox"/> Clopidogrel/ Prasugrel <input type="checkbox"/> Lipid lowering Statin <input type="checkbox"/> Beta-blocker <input type="checkbox"/> Ivabradine <input type="checkbox"/> Alpha Blocker <input type="checkbox"/> ACE Inhibitor <input type="checkbox"/> Angiotensin II Receptor Blocker <input type="checkbox"/> Nitrate <input type="checkbox"/> GTN spray/tablets Frequency of use of GTN: <input type="checkbox"/> Calcium Channel Blocker (name): <input type="checkbox"/> Potassium Channel Activators <input type="checkbox"/> Diuretic <input type="checkbox"/> Warfarin <input type="checkbox"/> NOAC <input type="checkbox"/> Anti-arrhythmic (specify type): <input type="checkbox"/> Insulin <input type="checkbox"/> Other medications (please specify)			

GP exercise referral form continued...

INVESTIGATIONS			
ECG ETT: <input type="checkbox"/> Y <input type="checkbox"/> N Date: <input type="checkbox"/> Full <input type="checkbox"/> Modified <input type="checkbox"/> Diagnostic Result: <input type="checkbox"/> +ve <input type="checkbox"/> -ve <input type="checkbox"/> Functional METS:	BP: Pulse:	Echocardiogram: <input type="checkbox"/> Y <input type="checkbox"/> N Date: EF%: LV Function <input type="checkbox"/> Good <input type="checkbox"/> Moderate <input type="checkbox"/> Poor <input type="checkbox"/> Not known	Angiogram <input type="checkbox"/> Y <input type="checkbox"/> N Date: Perfusion scan: <input type="checkbox"/> Y <input type="checkbox"/> N Date: Myocardial CT scan: <input type="checkbox"/> Y <input type="checkbox"/> N Date: MRI scan: <input type="checkbox"/> Y <input type="checkbox"/> N Date: Result/treatment planned:
OTHER MEDICAL HISTORY			
<input type="checkbox"/> Stroke <input type="checkbox"/> Epilepsy <input type="checkbox"/> COPD/Asthma <input type="checkbox"/> Claudication <input type="checkbox"/> Musculoskeletal problems <input type="checkbox"/> Neuro problems Other (please specify):			
CHD RISK FACTORS (please tick all applicable)			
Smoker <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Ex-smoker <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Physical Inactivity <input type="checkbox"/> Diabetes: Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> <input type="checkbox"/> Hypertension <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Excess Alcohol <input type="checkbox"/> FH of CVD <input type="checkbox"/> BMI: _____ Waist circumference: _____			
IMPORTANT NOTICE – the patient:		PATIENT – INFORMED CONSENT	
<input type="checkbox"/> is clinically stable <input type="checkbox"/> does not exhibit contraindications to exercise as per page 1 of this form <input type="checkbox"/> is not awaiting further cardiology investigations or treatment <input type="checkbox"/> is awaiting further follow-up or treatment (please specify): GP's signature: PRINT NAME: Date:		<ul style="list-style-type: none"> • I agree for the above information to be passed on to the Cardiac Rehab Exercise Instructor. • I understand that I am responsible for monitoring my own responses during exercise and will inform the instructor of any new or unusual symptoms. • I will inform the Exercise Instructor of any changes in my medication and the results of any future investigations or treatment. Patient's signature: Date:	

Thank you for your time. Please ask your patient to collect this form from your receptionist, so they can pass it on to our Cardiac Rehabilitation Exercise Instructors for review.



North Gwent
Cardiac Rehabilitation
and Aftercare Charity

- We are a registered charity (no. 1056887), set up in 1990 to provide community-based cardiac rehab exercise classes at venues across North Monmouthshire and Blaenau Gwent.
- Our circuit-based classes are tailored specifically for people who have either had a heart event and completed their Phase 3 hospital-based cardiac rehab programme, or who are living with heart and cardiovascular disorders, including heart failure.
- Our Cardiac Rehabilitation Exercise Instructors are all qualified through the British Association for Cardiovascular Prevention and Rehabilitation (BACPR), the gold-standard for instructors.
- We aim to make safe, regular exercise easy and affordable for our members and subsidise our classes through fundraising, donations and grants. We currently charge £5 per class for members (annual membership fee: £10), or £6 for non-members.
- We offer a weekly timetable of 10 classes at 8 different locations, including Tredegar, Ebbw Vale, Nantyglo, Blaenavon, Abertillery, Abergavenny, Usk and Monmouthshire.
- Our founder and chairperson is Jacky Miles MBE PhD, a former cardiac nurse with the Aneurin Bevan University Hospital Board. During her time with ABUHB, Jacky developed an award-winning multidisciplinary hospital-based cardiac rehabilitation programme and went on to qualify as a nurse consultant. She is currently Associate Professor with the School of Care Sciences at the University of South Wales.
- To find out more, visit our website, cardiac-rehab.org.uk, email info@cardiac-rehab.org.uk, or call the Charity Secretary, Tony Lowery, on 07856 692 148.