

CHD GP EXERCISE REFERRAL FORM



To be completed by the Referring Doctor or designated health professional

PATIENTS DETAILS:		REFERRERS DETAILS:	
Name :		Name:	
Home Tel :	Work Tel:	Profession:	Tel:
Address :		Surgery / Department:	
Age:	DOB:	Address:	Postcode:
CARDIAC HISTORY		ANGINA/ARRHYTHMIA HISTORY	
<p style="text-align: center;">NO previous cardiac history <input type="checkbox"/></p> <p style="text-align: center;">Please tick those applicable below for all previous events giving dates where possible:</p>		<p style="text-align: center;">Current Angina Y <input type="checkbox"/> N <input type="checkbox"/></p>	
STEMI <input type="checkbox"/>	Date: _____ Site: _____	Date of onset:	
NSTEMI <input type="checkbox"/>	Date: _____	Details of angina:	
Stable angina <input type="checkbox"/>	Date: _____	Relieved by rest or GTN: Y <input type="checkbox"/> N <input type="checkbox"/>	
CABG <input type="checkbox"/>	Date: _____	Arrhythmias Y <input type="checkbox"/> N <input type="checkbox"/>	
Primary PCI <input type="checkbox"/>	Date: _____	Date of onset:	
Elective PCI <input type="checkbox"/>	Date: _____	Details of arrhythmias:	
Heart Failure <input type="checkbox"/>	Date: _____	ICD/Pacemaker date fitted:	
NYHA classification	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/>	Details/Settings:	
MEDICATION (PLEASE TICK THOSE CURRENTLY TAKEN)			
Aspirin <input type="checkbox"/> Other anti platelet <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 <input type="checkbox"/> Frequency of use of GTN _____ Calcium Channel Blocker <input type="checkbox"/> Name _____ Potassium Channel Activators <input type="checkbox"/> Diuretic <input type="checkbox"/> Warfarin <input type="checkbox"/> Anti – arrhythmic <input type="checkbox"/> Specify type _____ Insulin <input type="checkbox"/> Other medications _____			
INVESTIGATIONS			
ECG ETT Y <input type="checkbox"/> N <input type="checkbox"/>	B P	LV Function <input type="checkbox"/> Good	Angiogram Y <input type="checkbox"/> N <input type="checkbox"/>
Date		<input type="checkbox"/> Moderate	Result
Result +ve <input type="checkbox"/> -ve <input type="checkbox"/>	Pulse	<input type="checkbox"/> Poor	
		<input type="checkbox"/> Not Known	
OTHER MEDICAL HISTORY			
Stroke <input type="checkbox"/> Epilepsy <input type="checkbox"/> COPD/Asthma <input type="checkbox"/> Claudication <input type="checkbox"/> Musculoskeletal problems <input type="checkbox"/> Neuro problems <input type="checkbox"/> Other _____			
CHD RISK FACTORS (tick those applicable)			
Smoker Y <input type="checkbox"/> N <input type="checkbox"/> Ex <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Physical Inactivity <input type="checkbox"/> Diabetes: Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> Hypertension <input type="checkbox"/> Stress affecting health <input type="checkbox"/> Excess Alcohol <input type="checkbox"/> FH of CVD <input type="checkbox"/> BMI _____ Waist Circ: _____			
IMPORTANT NOTICE - the patient:-		PATIENT INFORMED CONSENT	
is clinically stable <input type="checkbox"/> does not exhibit contraindications to exercise as per protocol <input type="checkbox"/> is not awaiting further cardiology investigations or treatment <input type="checkbox"/> or is awaiting further follow up or treatment <input type="checkbox"/> Please specify: _____		<ul style="list-style-type: none"> I agree for the above information to be passed on to the 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 instructor of any changes in my medication and the results of any future investigations or treatment. 	
Referrers Signature	PRINT NAME		
GP signature	PRINT NAME		
Date:			
		Patient Signature:	
		Date:	