CHD GP EXERCISE REFERRAL FORM

To be completed by the Referring Doctor or designated health professional

PATIENTS DETAILS:	REFERRERS DETAILS:
Name : Home Tel : Work Tel: Address : Age: DOB:	Name: Profession: Tel: Surgery / Department: Address: Postcode:

CARDIAC HISTORY

NO previous cardiac history ☐
Please tick those applicable below for all previous events giving dates where possible:

STEMI	☐ Date:	Site:
NSTEMI	☐ Date:	
Stable angina	☐ Date:	
CABG	☐ Date:	
Primary PCI	☐ Date:	
Elective PCI	☐ Date:	
Heart Failure	☐ Date:	
NYHA classification	1 ☐ 2 ☐ 3 ☐ 4 ☐	

ANGINA/ARRHYTHMIA HISTORY

Current Angina Y ☐ N ☐

Date of onset:

Details of angina:

Relieved by rest or GTN: Y ☐ N ☐

Arrhythmias Y ☐ N ☐

Date of onset:

Details of arrhythmias:

ICD/Pacemaker date fitted:

Details/Settings:

MEDICATION (PLEASE TICK THOSE CURRENTLY TAKEN)

Aspirin ☐ Other anti platelet ☐ Lipid lowering Statin ☐ Beta-blocker ☐ Ivabradine ☐ Alpha Blocker ☐
ACE Inhibitor ☐ Angiotensin II Receptor Blocker ☐ Nitrate ☐ GTN Spray/tablets ☐ Frequency of use of GTN
Calcium Channel Blocker ☐ Name Potassium Channel Activators ☐ Diuretic ☐ Warfarin ☐ Anti – arrhythmic ☐ Specify type Insulin ☐ Other medications

INVESTIGATIONS

ECG ETT Y ☐ N ☐ Date Result +ve☐ -ve ☐	B P Pulse	LV Function ☐ Good ☐ Moderate ☐ Poor ☐ Not Known	Angiogram Y ☐ N ☐ Result

OTHER MEDICAL HISTORY

Stroke ☐ Epilepsy ☐ COPD/Asthma ☐ Claudication ☐ Musculoskeletal problems ☐ Neuro problems ☐ Other

CHD RISK FACTORS (tick those applicable)

Smoker Y ☐ N ☐ Ex ☐ High Cholesterol ☐ Physical Inactivity ☐ Diabetes: Type 1 ☐ Type 2 ☐
Hypertension ☐ Stress affecting health ☐ Excess Alcohol ☐ FH of CVD ☐ BMI Waist Circ:

IMPORTANT NOTICE - the patient:-	PATIENT INFORMED CONSENT
is clinically stable ☐ does not exhibit contraindications to exercise as per protocol ☐ is not awaiting further cardiology investigations or treatment ☐ or is awaiting further follow up or treatment ☐ Please specify: **Referrers Signature** PRINT NAME **GP signature** PRINT NAME Date:	• 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**. Patient Signature: Date: