

Cardiac Rehabilitation Referral Form

Inclusion Criteria: Patients who have had an acute event/admission within the past 6 months for

- | | | | |
|---------|-----------------|-----------------|-----------------|
| → STEMI | → NSTEMI | → Angina | → PCI |
| → CABG | → Valve Surgery | → Heart Failure | → ICD Insertion |

Exclusion Criteria:

- | | | | |
|--|---|---|--|
| → Unstable Angina | → Resting systolic SIP of > 200 or resting diastolic SIP of > 110 | → Orthostatic Sip drop of >20 mm with symptoms | → Critical aortic stenosis (peak systolic pressure gradient of >50 with an aortic valve orifice area of <0.75cm ² in an average size adult) |
| → Acute systemic illness or fever | → Uncontrolled sinus tachycardia (> 120 beats per min) | → Uncontrolled atrial or ventricular arrhythmias | → Decompensated congestive heart failure |
| → 30 AV block (without pacemaker) | → Active pericarditis or myocarditis | → Recent Embolism | → Thrombophlebitis |
| → Resting ST segment displacement (>2mm) | → Poor mental function | → Uncontrolled diabetes (resting blood sugar 22 mmol/L) | → Other metabolic conditions such as thyroiditis, hypokalaemia or hyperkalaemia, hypovolemia |

Consent: Has your patient consented to “share” their medical records ☐ Yes ☐ No.
If no, or GP not on Systm1, then we will require a GP summary along with the referral

Incomplete referral forms will be returned to the referrer. Any queries or questions please call 0800 012 1858. Email completed referrals, plus patient summary to BOC.clinicalServices@nhs.net Fax completed referrals plus patient summary to 0845 600 0096

Patient Details

Name	
DOB	NHS No.
Address	
Postcode	
Tel No. (Home)	
Tel No. (Work/Mobile)	

ECHO

LV Function if known _____ Date _____

Diagnosis

- Date:
- | | | | |
|--|--|--------------------------------|---------------------------------|
| <input type="checkbox"/> Angina | <input type="checkbox"/> Unstable Angina | <input type="checkbox"/> STEMI | <input type="checkbox"/> NSTEMI |
| <input type="checkbox"/> Valve Disease | <input type="checkbox"/> ICD | <input type="checkbox"/> HF | <input type="checkbox"/> Other |

Treatment

- Date:
- | | | | |
|---------------------------------------|--|-------------------------------|--------------------------------|
| <input type="checkbox"/> PCI | <input type="checkbox"/> PPCI | <input type="checkbox"/> CABG | <input type="checkbox"/> Valve |
| <input type="checkbox"/> CABG & Valve | <input type="checkbox"/> Medical Treat | <input type="checkbox"/> ICD | <input type="checkbox"/> Other |

Medication

- | | | | |
|--------------------------------------|---------------------------------|---------------------------------------|--|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Statin | <input type="checkbox"/> Beta Blocker | <input type="checkbox"/> Ace Inhibitor |
| <input type="checkbox"/> Clopidogrel | | | |

Risk Factors

- | | | | |
|--|---------------------------------------|-----------------------------------|---|
| <input type="checkbox"/> Smoker | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Family History |
| <input type="checkbox"/> Dyslipidaemia | | | |

Other Information

Preferred Cardiac Rehabilitation Venue

- | | | |
|---|---|--|
| <input type="checkbox"/> Lighthouse Project - Middleton | <input type="checkbox"/> Castlemere Community Centre - Rochdale | <input type="checkbox"/> Back O'th Moss Community Centre - Heywood |
|---|---|--|

Referrer Details

Name:

Job Title:

Contact Telephone Number:

Address: