BACPR Transfer Form

BACPR

Patient's Name		Telephone Number	
Address			
		Postcode	
Age		Date of Birth		Email	
Emergency Contact Number		Name		Relationship	
GP		Telephone Number	
Surgery Name			

Current Cardiovascular Event

Most Recent Cardiovascular Event		Date
Details		
Complications		

Current Angina (please tick) Yes ☐ No ☐

Date of Onset ☐ Details of Angina ☐

Triggers ☐

Relieved by GTN Yes ☐ No ☐ Relieved by Rest Yes ☐ No ☐ Frequency of GTN ☐

Arrhythmias (please tick) Yes ☐ No ☐

Date of Onset ☐ Details of Arrhythmias ☐

Devices ICD ☐ Pacemaker ☐ CRT ☐ Details/Settings ☐

Heart Failure ☐ Date ☐ **NYHA Classification** 1 ☐ 2 ☐ 3 ☐ 4 ☐

Investigations

Echocardiogram Date ☐ LV Function Good ☐ Moderate ☐ Poor ☐ Ejection Fraction ☐ %

Other Investigations ☐ **Ongoing Investigations** ☐

Cardiovascular History Prior to Above Event

If NO previous Cardiovascular History (please tick) ☐

Other Medical History

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

Diabetes Type 1 ☐ Diabetes Type 2 ☐

Other/ Comments ☐

	Patient Name	

Medication

Please tick those currently taken:

ACE Inhibitor ☐	Alpha Blocker ☐	Angiotensin II Receptor Blocker ☐	Anti-arrhythmic ☐	Specify type
Aspirin ☐	Beta Blocker ☐	Calcium Channel Blocker ☐	Name	
Clopidogrel / Prasugrel / Ticagrelor ☐	Diuretic ☐	DOAC / NOAC ☐	GTN Spray / Tablets ☐	Insulin ☐
Ivabradine ☐	Lipid Lowering Medications ☐	Specify type	Metformin ☐	Nitrate ☐
Potassium Channel Activators ☐	Sacubitril / Valsartan ☐	SGLT2 Inhibitors ☐	Warfarin ☐	Other Medications

CVD Risk Factors

Please tick those that are applicable:

Smoker	Yes ☐ No ☐ Ex ☐	Diabetes	Type 1 ☐ Type 2 ☐	BMI	Waist Circ
High Cholesterol ☐	Physical Inactivity prior to Phase III ☐		Hypertension ☐		Excess Alcohol ☐
Anxiety ☐	Depression ☐	Family History of CVD ☐			

Core Rehab Exercise Status

Date Started _____ Date Completed _____ Number of Exercise Sessions Attended _____

Mode: In-person ☐ Remote ☐ Hybrid _____ Interval ☐ *or* Continuous ☐

Final Session detail: Time per CV station ___ mins Time for AR station ___ mins Total CV ___ Total AR ___

Submax Functional Test Results: Date ___ Description of Test ___ Peak METS ___ Peak HR ___ %HRR ___

Symptoms ___ Reasons for Stopping ___ Other ___

Pre-exercise BP Final session: ___ Pre-exercise HR Final Session ___ Reg ☐ Irreg ☐

Prescribed Training Heart Rate Range ___ Achieved Training Heart Rate Range ___ Average RPE ___ Able to Self Pace No ☐ Yes ☐

Adaptations / Limitations ___ Cardiac Symptoms During Exercise: Please Specify ___

Home Exercise Programme / Exercise related goals ___

Patient Informed Consent

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	
		Verbal Consent given by Patient ☐	

Important Notice

At Time of Transfer this Patient: is clinically stable ☐ concords with prescribed medication ☐ is NOT awaiting further follow up or treatment ☐

is awaiting further follow up or treatment ☐ Please Specify _____

Cardiovascular Rehabilitation Professional Signature

Signature		Date	
		Email	
Name		Job Title	
Contact Address		Tel No.	