Heart

Failure

Date

Details of Arrhythmias

Date of Onset

Date of Onset

**BACPR Transfer Form**

Current Angina (please tick)

Arrhythmias (please tick)

Devices

ICD

Pacemaker

CRT

Details/Settings

**Other Medical History**

Musculoskeletal problems

Stroke

Epilepsy

Claudication

COPD/Asthma

Neuro problems

Diabetes Type 1

Diabetes Type 2

1/2

Other/ Comments

Click or tap here to enter text.

[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] Click or tap here to enter text.

**Cardiovascular History Prior to Above Event**

**Investigations**

Echocardiogram Date LV Function Good Moderate Poor Ejection Fraction

**Other Investigations Ongoing Investigations**

Click or tap here to enter text.

Click or tap here to enter text.

%

[ ] [ ] [ ] Click or tap here to enter text.

NYHA Classiﬁcation 1 2 3 4

[ ] [ ] [ ] [ ] Click or tap here to enter text.

[ ] Click or tap here to enter text.

[ ] [ ] [ ] Click or tap here to enter text.

Click or tap here to enter text.

 Details of Angina

Triggers

Relieved by GTN Yes [ ]  No [ ]  Relieved by Rest Yes [ ]  No [ ]  Frequency of GTN

Click or tap here to enter text.

Click or tap here to enter text.

Click or tap here to enter text.

Click or tap here to enter text.

**Current Cardiovascular Event**

Most Recent Cardiovascular Event

Click or tap here to enter text.

Date

Click or tap here to enter text.

Details

Click or tap here to enter text.

Complications

Click or tap here to enter text.

GP

Click or tap here to enter text.

Telephone Number

Click or tap here to enter text.

Surgery Name

Click or tap here to enter text.

Relationship

Click or tap here to enter text.

Name

Click or tap here to enter text.

Emergency Contact Number

Click or tap here to enter text.

Patient’s Name

Click or tap here to enter text.

Click or tap here to enter text.

Address

Postcode

Age

Email

Date of Birth

Click or tap here to enter text.

If NO previous Cardiovascular History (please tick) [ ]

Click or tap here to enter text.

No [ ]

Yes [ ]

No [ ]

Yes [ ]

Click or tap here to enter text.

Click or tap here to enter text.

Click or tap here to enter text.

Telephone Number

Click or tap here to enter text.

Click or tap here to enter text.

Click or tap here to enter text.

Click or tap here to enter text.

Click or tap here to enter text.

Click or tap here to enter text.

Click or tap here to enter text.

Signature

Click or tap here to enter text.

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

Achieved Training
Heart Rate Range

Click or tap here to enter text.

Reasons for Stopping

Click or tap here to enter text.

Click or tap here to enter text.

Anti-arrhythmic

Yes

No

Able to Self Pace

Average RPE

Prescribed Training
Heart Rate Range

Other

Symptoms

Name

Specify
type

 **Medication**

Please tick those currently taken:

GTN Spray / Tablets

Insulin

Specify type

Metformin

Nitrate

Lipid Lowering 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**

 **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.

 **Important Notice**

Cardiovascular Rehabilitation Professional Signature

Date

Email

Name

Job Title

Contact Address

Tel No.

2/2

Verbal Consent given by Patient

[ ] Date

Click or tap here to enter text.

Patient Signature

Click or tap here to enter text.

Home Exercise Programme / Exercise related goals

Click or tap here to enter text.

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

Adaptations / Limitations Cardiac Symptoms During Exercise: Please Specify

Click or tap here to enter text.

Click or tap here to enter text.

Click or tap here to enter text.

Click or tap here to enter text.

[ ] [ ] Click or tap here to enter text.

Click or tap here to enter text.

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

Click or tap here to enter text.

Click or tap here to enter text.

Click or tap here to enter text.

[ ] [ ] [ ] Click or tap here to enter text.

Click or tap here to enter text.

Date Started Date Completed Number of Exercise Sessions Attended

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

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

Click or tap here to enter text.

mins

mins

[ ] [ ] Click or tap here to enter text.

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Click or tap here to enter text.

Click or tap here to enter text.

[ ] [ ] [ ] [ ] [ ] [ ] [ ] Click or tap here to enter text.

Click or tap here to enter text.

[ ] [ ] [ ] [ ] [ ] Warfarin

Other Medications

[ ] Click or tap here to enter text.

SGLT2 Inhibitors

[ ] Sacubitril / Valsartan

[ ] Potassium Channel Activators

[ ] Ivabradine

[ ] [ ] [ ] [ ] Click or tap here to enter text.

[ ] [ ] DOAC / NOAC

[ ] Clopidogrel / Prasugrel /
Ticagrelor

Diuretic

[ ] [ ] Calcium Channel

Blocker

Click or tap here to enter text.

[ ] Beta Blocker

[ ] Aspirin

[ ]

Click or tap here to enter text.

[ ] Angiotensin II Receptor Blocker

[ ] Alpha Blocker

[ ] ACE Inhibitor

[ ] Patient Name