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.

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.

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