

Patient's Name	<input type="text"/>	Telephone number	<input type="text"/>
Address	<input type="text"/>		
	Postcode <input type="text"/>		
Age	<input type="text"/>	Date of birth	<input type="text"/>
	Email <input type="text"/>		
Emergency Contact Number	<input type="text"/>	Name	<input type="text"/>
	Relationship <input type="text"/>		

GP	<input type="text"/>	Telephone Number	<input type="text"/>
Surgery name	<input type="text"/>		
Address	<input type="text"/>		
	Postcode <input type="text"/>		

Current Cardiac Event

Most Recent Cardiac Event	<input type="text"/>	Date	<input type="text"/>
Details	<input type="text"/>		
Complications	<input type="text"/>		

Cardiac History prior to above event

If NO previous cardiac history (please tick)

Please tick those applicable below for all previous events giving dates where possible:

STEMI	<input type="checkbox"/>	Date	<input type="text"/>	NSTEMI	<input type="checkbox"/>	Date	<input type="text"/>	PCI	<input type="checkbox"/>	Primary	<input type="checkbox"/>	Elective	<input type="checkbox"/>	Date	<input type="text"/>
Unstable Angina	<input type="checkbox"/>	Date	<input type="text"/>	Stable Angina	<input type="checkbox"/>	Date	<input type="text"/>	CABG	<input type="checkbox"/>	Date	<input type="text"/>				
Valve	<input type="checkbox"/>	<input type="text"/>	Repair	<input type="checkbox"/>	Replacement	<input type="checkbox"/>	Date	<input type="text"/>	Cardiac Arrest	<input type="checkbox"/>	Date	<input type="text"/>			
Heart Failure	<input type="checkbox"/>	Date	<input type="text"/>	NYHA classification	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3	<input type="checkbox"/>	4	<input type="checkbox"/>			
Other	<input type="text"/>														

Current Angina (please tick) Yes No

Date of onset	<input type="text"/>	Details of angina	<input type="text"/>
Triggers	<input type="text"/>		Relieved by rest or GTN Yes <input type="checkbox"/> No <input type="checkbox"/>

Arrhythmias (please tick) Yes No

Date of onset	<input type="text"/>	Details of arrhythmias	<input type="text"/>
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Devices	ICD <input type="checkbox"/>	Pacemaker <input type="checkbox"/>	CRT <input type="checkbox"/>	Details/Settings	<input type="text"/>
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Medication

Please tick those currently taken:

ACE Inhibitor	<input type="checkbox"/>	Alpha Blocker	<input type="checkbox"/>	Angiotensin II Receptor Blocker	<input type="checkbox"/>	Anti-arrhythmic	<input type="checkbox"/>	Specify type	<input type="text"/>
Aspirin	<input type="checkbox"/>	Beta-blocker	<input type="checkbox"/>	Calcium Channel Blocker	<input type="checkbox"/>	Name	<input type="text"/>		
Clopidogrel / Prasugrel / Ticagrelor	<input type="checkbox"/>	Diuretic	<input type="checkbox"/>	DOAC/NOAC	<input type="checkbox"/>	GTN Spray/tablets	<input type="checkbox"/>	Frequency of use of GTN	<input type="text"/>
Insulin	<input type="checkbox"/>	Ivabradine	<input type="checkbox"/>	Statin	<input type="checkbox"/>	Nitrate	<input type="checkbox"/>	Potassium Channel Activators	<input type="checkbox"/>
Warfarin	<input type="checkbox"/>	Other medications	<input type="text"/>						

Patient Name

Investigations

Echocardiogram Date LV Function Good Moderate Poor Ejection Fraction %

Other Investigations

CHD 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

Other Medical History

Stroke Epilepsy Claudication COPD/Asthma Musculoskeletal problems Neuro problems

Other

Early Rehab Exercise Status

Date started Date completed Number of exercise sessions attended

Mode: Circuit or Gym 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

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: Frequency Intensity Time Type

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

Important Notice

At time of transfer this patient: is clinically stable concurs with prescribed medication is NOT awaiting further follow up or treatment
is awaiting further follow up or treatment Please specify

Cardiac Rehabilitation Professional Signature

Signature Date
Email

Name Job Title

Contact Address Tel no.