

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"/>		

Current Cardiovascular Event

Most Recent Cardiovascular Event	<input type="text"/>	Date	<input type="text"/>
Details	<input type="text"/>		
Complications	<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 GTN	Yes <input type="checkbox"/> No <input type="checkbox"/>	Relieved by Rest	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Frequency of GTN <input type="text"/>		

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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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"/>
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Investigations

Echocardiogram Date	<input type="text"/>	LV Function	Good <input type="checkbox"/>	Moderate <input type="checkbox"/>	Poor <input type="checkbox"/>	Ejection Fraction	<input type="text"/>	%
Other Investigations	<input type="text"/>	Ongoing Investigations	<input type="text"/>					

Cardiovascular History Prior to Above Event

If NO previous Cardiovascular History (please tick)

<input type="text"/>

Other Medical History

Stroke	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	Claudication	<input type="checkbox"/>	COPD/Asthma	<input type="checkbox"/>	Musculoskeletal problems	<input type="checkbox"/>	Neuro problems	<input type="checkbox"/>
Diabetes Type 1	<input type="checkbox"/>	Diabetes Type 2	<input type="checkbox"/>								

Other/Comments	<input type="text"/>
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Patient Name

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"/>	Insulin <input type="checkbox"/>
Ivabradine <input type="checkbox"/>	Lipid Lowering Medications <input type="checkbox"/>	Specify type <input type="text"/>	Metformin <input type="checkbox"/>	Nitrate <input type="checkbox"/>
Potassium Channel Activators <input type="checkbox"/>	Sacubitril / Valsartan <input type="checkbox"/>	SGLT2 Inhibitors <input type="checkbox"/>	Warfarin <input type="checkbox"/>	Other Medications <input type="text"/>
<input type="text"/>				

CVD Risk Factors

Please tick those that are applicable:

Smoker	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Ex <input type="checkbox"/>	Diabetes	Type 1 <input type="checkbox"/>	Type 2 <input type="checkbox"/>	BMI <input type="text"/>	Waist Circ <input type="text"/>
High Cholesterol <input type="checkbox"/>	Physical Inactivity prior to Phase III <input type="checkbox"/>			Hypertension <input type="checkbox"/>	Excess Alcohol <input type="checkbox"/>			
Anxiety <input type="checkbox"/>	Depression <input type="checkbox"/>	Family History of CVD <input type="checkbox"/>						

Core Rehab Exercise Status

Date Started <input type="text"/>	Date Completed <input type="text"/>	Number of Exercise Sessions Attended <input type="text"/>				
Mode:	In-person <input type="checkbox"/>	Remote <input type="checkbox"/>	Hybrid <input type="text"/>	Interval <input type="checkbox"/>	or	Continuous <input type="checkbox"/>
Final Session detail:	Time per CV station <input type="text"/> mins	Time for AR station <input type="text"/> mins	Total CV <input type="text"/>	Total AR <input type="text"/>		
Submax Functional Test Results:	Date <input type="text"/>	Description of Test <input type="text"/>	Peak METS <input type="text"/>	Peak HR <input type="text"/>	%HRR <input type="text"/>	
Symptoms <input type="text"/>	Reasons for Stopping <input type="text"/>	Other <input type="text"/>				
Pre-exercise BP Final session: <input type="text"/>	Pre-exercise HR Final Session <input type="text"/>	Reg <input type="checkbox"/>	Irreg <input type="checkbox"/>			
Prescribed Training Heart Rate Range <input type="text"/>	Achieved Training Heart Rate Range <input type="text"/>	Average RPE <input type="text"/>	Able to Self Pace	No <input type="checkbox"/>	Yes <input type="checkbox"/>	
Adaptations / Limitations <input type="text"/>	Cardiac Symptoms During Exercise: Please Specify <input type="text"/>					
Home Exercise Programme / Exercise related goals <input type="text"/>						

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 <input type="text"/>	Date <input type="text"/>
Verbal Consent given by Patient <input type="checkbox"/>	

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

Cardiovascular Rehabilitation Professional Signature

Signature <input type="text"/>	Date <input type="text"/>
Email <input type="text"/>	
Name <input type="text"/>	Job Title <input type="text"/>
Contact Address <input type="text"/>	Tel No. <input type="text"/>