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.