ACTIVE TOGETHER CARDIOPULMONARY REHABILITATION (PHASE IV) AND COMPLEX PATIENT REFERRAL FORM

Personal Information

Patient's Full Name:

Address:

Postcode:

Telephone No:

Email:

What best describes their gender?: ☐ Male ☐ Female ☐ Prefer to self describe ☐ Prefer not to say

Date of Birth:

Fastrack? ☐ Yes

Cardiac History (if applicable)
(please select all that apply)

- ☐ Angina (triggers/relief):
- ☐ Angioplasty/stent Date:
- ☐ Arrhythmias (Please state):
- ☐ BP reading
- ☐ CABG Date:
- ☐ Heart failure
- ☐ ICD (type & settings):
- ☐ MI Date:
- ☐ Normal RHR
- ☐ Pacemaker
- ☐ AV Repair ☐ AV Replace ☐ MV Repair ☐ MV Replace

Current Medication (if applicable)
(please select all that apply)

☐ Ace Inhibitor	☐ Anti-arrhythmic
☐ Aspirin	☐ Beta blocker
☐ Calcium channel blocker	☐ Clopidogrel
☐ Digoxin	☐ Diuretic
☐ Inhaler	☐ Nitrate
☐ Statin	☐ Warfarin
☐ Clopidogrel/Ticagrelor/Prasurgel	☐ Anticoagulant

☐ Other please state:

LV Function ☐ Good ☐ Moderate ☐ Poor ☐ Unknown Ejection fraction %

Submax Functional Test results Test type: Date:
Peak METS: Peak HR: Level:

Has the patient attended a COVID Recovery/Rehabilitation Programme? ☐ Yes Date: ☐ No

Additional Information (e.g. other relevant cardiac history/ investigations, physical limitations, medication, accessibility requirements, physical activity preferences)

Other Medical History (please select all that apply)

- ☐ Diabetes mellitus (type 1) (controlled)
- ☐ Diabetes mellitus (type 2) (controlled)
- ☐ Musculoskeletal problems (please specify)
- ☐ Respiratory problems (please specify)
- ☐ Neuro problems (please specify)
- ☐ Claudication

Other relevant medical history:

☐ I deem the patient to be clinically complex, please specify why:

Referrer Authorisation

At the time of transfer I confirm the patient is:

Date:

- ☐ Clinically stable
- ☐ Compliant with prescribed medication
- ☐ NOT awaiting further follow up treatment
- ☐ awaiting further follow up treatment (Please specify)

Address of referrer:

Name of referrer:	Job title of referrer:
Signature of referrer:	Phone number of referrer:

Patient Informed Consent (please obtain this verbally from the patient)

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. ☐

Please securely email this form to the relevant physical activity service.

Blaby	0116 2727523	exercise.referral@blaby.gov.uk
Charnwood	01509 634673	GPreferral@charnwood.gov.uk
Harborough	07879 828187	exercisereferral@harborough.gov.uk
Hinckley & Bosworth	01455 255870	exercisereferral@hinckley-bosworth.gov.uk
Melton	01664 502416	exercisereferral@melton.gov.uk
North West Leicestershire	01530 454785	exercise.referral@nwleicestershire.gov.uk
Oadby & Wigston	0116 2727523	exercisereferral@oadby-wigston.gov.uk
Rutland	01572 720936	activerutlandhealth@rutland.gov.uk