

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]

- | | |
|---|--|
| <input type="checkbox"/> Ace Inhibitor | <input type="checkbox"/> Anti-arrhythmic |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Beta blocker |
| <input type="checkbox"/> Calcium channel blocker | <input type="checkbox"/> Clopidogrel |
| <input type="checkbox"/> Digoxin | <input type="checkbox"/> Diuretic |
| <input type="checkbox"/> Inhaler | <input type="checkbox"/> Nitrate |
| <input type="checkbox"/> Statin | <input type="checkbox"/> Warfarin |
| <input type="checkbox"/> Clopidogrel/Ticagrelor/Prasurgel | <input type="checkbox"/> Anticoagulant |
| <input type="checkbox"/> 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	07966 535760	activerutlandhealth@rutland.gov.uk