# BACPR Exercise Instructor Transfer Form

Patients Name :

Tel :

Address : Age: DOB:

| | |
|---|---|
| Emergency Contact Number: | GP: Tel: |
| Name: | Surgery: |
| Relationship: | Address: |

## CURRENT CARDIAC EVENT

| | | |
|---|---|---|
| Most Recent Cardiac Event: | Details: | Complications: |
| Date: | | |

## CARDIAC HISTORY PRIOR TO ABOVE EVENT

**NO previous cardiac history** ☐
Please tick those applicable below for all previous events giving dates where possible:

☐ STEMI: Size Site: Date:
☐ NSTEMI: Date:
☐ Unstable angina: Date:
☐ Stable angina: Date:
☐ CABG: Date:
PCI ☐ Primary ☐ Elective Date:
Cardiac Arrest: ☐ Primary ☐ Secondary Date:
☐ Valve Repair ☐ Replacement Date :
☐ Heart Failure: Date:
NYHA classification: 1☐ 2☐ 3☐ 4☐

## ANGINA/ARRHYTHMIA HISTORY

**Current Angina:** ☐ **Y** ☐ **N**
Date of onset:
Details of angina:
Triggers:
Relieved by rest or GTN: ☐ Y ☐ N

**Arrhythmias**
☐ **Y** ☐ **N**
Date of onset:
Details of arrhythmias:

**Devices**
ICD fitted:
Prophylactic ☐
Preventative ☐
Pacemaker fitted:
Details/Settings:

## MEDICATION (PLEASE TICK THOSE CURRENTLY TAKEN)

☐ Aspirin ☐ Other anti-platelet
☐ Lipid lowering
☐ Beta-blocker ☐ Ivabradine
☐ Alpha Blocker
☐ ACE Inhibitor ☐ Angiotensin II Receptor Blocker
☐ Nitrate
☐ GTN Spray/tablets Frequency of use of GTN:
☐ Calcium Channel Blocker Name
☐ Potassium Channel Activators

☐ Diuretic:
☐ Warfarin:
☐ Other oral anti-coagulant:
☐ Anti – arrhythmic Specify type:
☐ Insulin:
Other medications:

Significant side effects causing problems:

## INVESTIGATIONS

ECG ETT: ☐ Y ☐ N
Date:
☐ Full ☐ Modified
☐ Diagnostic
Result: ☐ +ve ☐ -ve
☐ Functional
METS:

Echocardiogram ☐ Y ☐ N
Date:
LV Function ☐ Good
☐ Moderate
☐ Poor
☐ Not Known
Ejection Fraction : %

Angiogram: ☐ Y ☐ N Date:
Perfusion scan ☐ Y ☐ N Date:
Myocardial CT Scan: ☐ Y ☐ N Date:
MRI Scan: ☐ Y ☐ N Date:
Result/Treatment planned:

## OTHER MEDICAL HISTORY

**No relevant medical history ☐ or please specify below:**

☐ Stroke: Date: Details:

☐ Epilepsy: Since: Details:

☐ COPD/Asthma: Since: Details:

☐ Claudication: Since: Details:

☐ Musculoskeletal problems: Since: Details:

☐ Neuro problems: Date: Details:

Other: Details:

## CHD RISK FACTORS (tick those applicable)

Smoker ☐ Y ☐ N ☐ Ex ☐ High Cholesterol ☐ Physical Inactivity prior to Phase III

Diabetes: ☐ Type 1 ☐ Type 2 ☐ Hypertension ☐ FH of CVD ☐ Excess Alcohol

☐ Anxiety ☐ Depression BMI: Waist Circ:

## EARLY REHAB EXERCISE STATUS

Date started:

Date completed:

Number of exercise sessions attended:

Mode: ☐ Circuit: or ☐ Gym:

**Total CV time ACHIEVED:**

Mins per CV station:

☐ Interval: AR time:

☐ Continuous:

Able to self pace: ☐ Y ☐ N

Adaptations/limitations:

Cardiac symptoms during exercise: ☐ Y ☐ N

please specify:

Pre exercise BP final session:

Pre exercise HR final session: ☐ reg ☐ irreg

Prescribed training heart rate range:

Achieved training heart rate range:

Average RPE:

Approx METs achieved if known:

Home exercises/activities:

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: xxxxxx

## IMPORTANT NOTICE

At time of transfer this patient:

☐ is clinically stable

☐ concords with prescribed medication

☐ is not awaiting further cardiology investigations or treatment or

☐ is awaiting further follow up or treatment. Please specify:

**Cardiac Rehabilitation Professional Signature:** Date:

Name: Tel:

Contact Address: