Cardiac Rehabilitation Service Referral Form

*(Post migration to INTS S1 unit version Nov 22)*

Date of referral……………………………………….

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| PATIENT DETAILS Name:  D.O.B:NHS Number:  | Address:Post Code: Tel. No:  |
| REFERRED BY Name: Designation: Tel. No:  |
| **REASON FOR REFERRAL / INCLUSION CRITERIA *(Please tick the primary reason for referral as listed below):*** Patient aged 18+ and registered to a Barnsley GP practice and / or resident within the Barnsley geographical area [ ]  **If no, referral will be rejected.**   |
| **Heart Failure** [ ] Has the patient had an echocardiogram? Yes [ ]  **If no, referral will be rejected.**Echo Findings: Mild [ ]  Moderate [ ]  Severe [ ]  Please attach if available. NYHA classification: 1 [ ]  2 [ ]  3 [ ]  | **Angina** [ ] **a)** Has the patient had angina symptoms in the last 2 years? Yes [ ]  **If no, referral will be rejected.****b)** Has the patient been revascularised since diagnosis? No [ ] Go to question c). Yes [ ] If Yes, has the patient had ongoing angina symptoms since revascularisation? Yes [ ]  **If no – referral will be rejected.** **c)** Does the patient have GTN spray prescribed? Yes [ ]  **If no, referral will be rejected.** | **Recent Surgery** [ ]   Please list the surgical procedure undertaken:Discharge letter accompanying the referral? Yes [ ]   | **Acute Myocardial Infarction** [ ] STEMI [ ]  NON-STEMI [ ]  ACS [ ]  Other [ ]  Cardiac advice booklet given to patient:Yes   [ ]                             No  [ ]    |
| **PAST MEDICAL HISTORY:** |
| **MEDICATIONS / ANY KNOWN DRUG ALLERGIES:** |
| **MOBILITY LEVEL:**Fully Independent [ ]  Uses a walking aid [ ] Requires a wheelchair [ ]  Other (please specify below):  |