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): | | | | |