# GP Exercise Referral Form – Cardiac Conditions

To be completed by the referring doctor or designated health professional

| **Patient’s details** | **Referrer’s details** |
| --- | --- |
| Name: | Name: |
| Home telephone: | Profession: |
| Work telephone: | Telephone: |
| Address: | Surgery/department: |
| Age: | Address: |
| Date of birth: | Postcode: |

**Cardiac history**

No previous cardiac history

(Please tick those applicable for all previous events giving dates where possible)

| **Cardiac history** | **Date** |
| --- | --- |
| STEMI |  |
| NSTEMI |  |
| Stable angina |  |
| CABG |  |
| Primary PCI  Elective PCI |  |
| Cardiac Arrest -  Primary  Secondary |  |
| Heart failure |  |
| NYHA classification 1 2 3 4 |  |
| Complications (Please State) |  |

| **Angina history** | **Arrhythmia history** |
| --- | --- |
| Current Angina: Yes  No | Arrhythmias: Yes  No |
| Date of onset: | Date of onset: |
| Details of angina: | Details of arrhythmias: |
| Relieved by rest or GTN: Yes  No | ICD/Pacemaker date fitted: |
|  | Details/settings: |

| **Medication** (Please tick those currently taken) |
| --- |
| Aspirin |
| Clopidogrel/Prasugrel |
| Lipid lowering Statin |
| 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 |
| Anti-arrhythmic  Specify type: |
| Insulin |
| Other medications: |

| **Investigations** |
| --- |
| ECG ETT Yes  No  Date:  Result +ve  -ve |
| BP:  Pulse: |
| LV Function Good  Moderate  Poor  Not known |
| Angiogram Yes  No  Result: |

| **Other medical history** |
| --- |
| Stroke |
| Epilepsy |
| COPD/asthma |
| Claudication |
| Musculoskeletal problems |
| Neuro problems |
| Other: |

| **CHD risk factors** (tick those applicable) |
| --- |
| Smoker Yes  No  Ex |
| High cholesterol |
| Physical inactivity |
| Diabetes Type 1  Type 2 |
| Hypertension |
| Stress affecting health |
| Excess alcohol |
| FH of CVD |
| BMI: |
| Waist circumference: |

**Important notice – the patient:**

Is clinically stable

Does not exhibit contraindications to exercise as per protocol

Is not awaiting further cardiology investigations or treatment  or is awaiting further follow up or treatment

Please specify:

Referrer’s signature:

GP signature:

Date:

**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:

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