

REFERRAL TO CARDIAC REHABILITATION (CR)

Where would the patient like to attend CR?Fax number.....

Seen by CR Nurse before discharge? Yes / No

Surname	First Name
Male/Female	DoB: Age:
Hospital No.	NHS No
Address	GP
PC Tel	PC Tel
EO Language:	Religion Interpreter required Y / N
	Date of Admission Date of Discharge

Diagnosis	ANGINA <input type="checkbox"/> UNSTABLE ANGINA <input type="checkbox"/> STEMI <input type="checkbox"/> NSTEMI <input type="checkbox"/> VALVE DISEASE <input type="checkbox"/> Other.....
Treatment:	PCI <input type="checkbox"/> PPCI <input type="checkbox"/> Medical Treatment <input type="checkbox"/> DES: LAD x RCA x CX x OM1 x Diagonal x Date: BMS: LAD x RCA x CX x OM1 x Diagonal x Date: <hr/> CABG <input type="checkbox"/> AV Repair <input type="checkbox"/> AV Replac <input type="checkbox"/> MV Repair <input type="checkbox"/> MV Replace <input type="checkbox"/> Date: Type of valve: Mechanical <input type="checkbox"/> Tissue <input type="checkbox"/> Number of grafts: Vessels grafted.....
Clinical	LV Function (<i>if known</i>): Good / Moderate / Poor LVEF : Troponin I: Troponin T:

Other relevant clinical information

Medications:	Aspirin		Clopidogrel		Beta Blocker		Omacor (post MI)	
	Warfarin		Statin		ACE Inhibitor		Other Medications:	

Risk Factors:	Family History Y / N	Alcohol >21u M or >14u F: Y/N	Total Cholesterol Trigs		LDL: HDL		Date

Height.....Weight..... BMI.....BP.....	Smoked in last 4 weeks Y / N	Dyslipidaemia Y / N	Hypertension Y / N	Fasting Glucose mmol/l Diabetes Y / N
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Hospital Referring	Name of person completing the form
Ward Referring:	Tel. no. of person completing the form:
Name of Consultant:	Does the patient know of this referral? Y / N

