CHD GP EXERCISE REFERRAL FORM

To be completed by the Referring Doctor or designated health professional Please print clearly

Patient Details

Name:_____
Address:
_____
_____
Postcode: _____D.O.B._____ Age:___
Telephone Home:_____
Telephone Work: _____

Referrer's Details

Name & Profession:_____
Surgery / Department: _____
Address: _____
_____
Postcode: _____
Telephone:_____

Cardiac History

✓ if applicable

MI: ❑ Date: _____
Angioplasty / Stent: ❑ Date:_____
CABG: ❑ Date:_____

Heart Failure: ❑ ICD: ❑ Pacemaker: ❑
Other Event/s:_____
_____ Date:_____

Current Angina: ❑ At Rest: ❑ On Exertion: ❑ GTN:❑ Current Dyspnoea: ❑ Arrhythmias:❑

Current Medication

✓ **if prescribed** (attach prescription list if available)

Aspirin	❑	Beta blocker	❑	Ace Inhibitor	❑	Statin	❑
Clopidogrel	❑	Warfarin	❑	Diuretic	❑	Nitrate	❑
Anti-arrhythmic	❑	Calcium channel blocker	❑	GTN	❑	Other:	_____

Investigations (if available)

ETT: Yes ❑ No ❑ Date: _____
Result:_____

LV Function:
Good ❑ Moderate ❑ Poor ❑

Current Status - CHD Risk Factors

Resting BP _____ Resting Heart Rate_____ BMI _____ Stable Type 1/Type 2 Diabetes ❑
Raised Cholesterol ❑ Physically Inactive ❑ Smoker ❑ Excess Alcohol ❑ Stress ❑

Past Medical History

✓ if applicable, please supply dates & details as far as possible

COAD / Asthma ❑ Epilepsy ❑ Hypertension ❑ Claudication ❑
CVA / Neuro. Problems ❑ Ortho/musc. skeletal problems ❑ Details:_____
Other considerations:_____

IMPORTANT NOTICE

- ❑ The patient exhibits no contraindication to exercise (as indicated on the protocol)
- ❑ The patient is clinically stable
- ❑ The patient is compliant with medication
- ❑ The patient is awaiting / not awaiting further medical or surgical treatment (see protocol)

REFERRER'S SIGNATURE:_____
Print Name:_____ Date:_____
GP's signature (if different from above):_____
Print Name: _____ Date:_____

PATIENT INFORMED CONSENT

I agree for the above information to be passed onto 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 also inform the instructor of any changes in my medication, the results of any investigations or treatment.

PATIENT SIGNATURE:_____
Print Name:_____Date:_____