# 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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