BACPR Transfer Form

Patient's Name		Telephone number	
Address			
	Postcode		
Age		Date of birth		Email	
Emergency Contact Number		Name		Relationship	
GP		Telephone Number	
Surgery name			
Address			
	Postcode		

Current Cardiac Event

Most Recent Cardiac Event		Date	
Details			
Complications			

Cardiac History prior to above event

If NO previous cardiac history (please tick) ☐

Please tick those applicable below for all previous events giving dates where possible:

STEMI ☐	Date		**NSTEMI** ☐	Date		**PCI** ☐	Primary ☐	Elective ☐	Date
Unstable Angina ☐	Date		**Stable Angina** ☐	Date		**CABG** ☐	Date		
Valve ☐		Repair ☐	Replacement ☐	Date		**Cardiac Arrest** ☐	Date		
Heart Failure ☐	Date		**NYHA classification**	1 ☐	2 ☐	3 ☐	4 ☐		
Other									

Current Angina (please tick) Yes ☐ No ☐

Date of onset		Details of angina	
Triggers		Relieved by rest or GTN	Yes ☐ No ☐

Arrhythmias (please tick) Yes ☐ No ☐

Date of onset		Details of arrhythmias	

Devices ICD ☐ Pacemaker ☐ CRT ☐ Details/Settings

Medication

Please tick those currently taken:

ACE Inhibitor ☐	**Alpha Blocker** ☐	**Angiotensin II Receptor Blocker** ☐	**Anti-arrhythmic** ☐	Specify type			
Aspirin ☐	**Beta-blocker** ☐	**Calcium Channel Blocker** ☐	Name				
Clopidogrel / Prasugrel / Ticagrelor ☐	**Diuretic** ☐	**DOAC/NOAC** ☐	**GTN Spray/tablets** ☐	**Frequency of use of GTN**			
Insulin ☐	**Ivabradine** ☐	**Statin** ☐	**Nitrate** ☐	**Potassium Channel Activators** ☐			
Warfarin ☐	**Other medications**						

Patient Name

Investigations

Echocardiogram Date | LV Function Good ☐ Moderate ☐ Poor ☐ | Ejection Fraction %

Other Investigations

CHD Risk Factors

Please tick those that are applicable:

Smoker Yes ☐ No ☐ Ex ☐ | Diabetes Type 1 ☐ Type 2 ☐ | BMI | Waist Circ

High Cholesterol ☐ | Physical Inactivity prior to Phase III ☐ | Hypertension ☐ | Excess Alcohol ☐

Anxiety ☐ | Depression ☐

Other Medical History

Stroke ☐ | Epilepsy ☐ | Claudication ☐ | COPD/Asthma ☐ | Musculoskeletal problems ☐ | Neuro problems ☐

Other

Early Rehab Exercise Status

Date started | Date completed | Number of exercise sessions attended

Mode: Circuit ☐ *or* Gym ☐ | Interval ☐ *or* Continuous ☐

Final Session detail: Time per CV station mins | Time for AR station mins | Total CV | Total AR

Submax Functional Test results: Date | Description of test | Peak METS | Peak HR

Symptoms | Reasons for stopping | Other

Pre-exercise BP final session: | Pre-exercise HR final session | Reg ☐ Irreg ☐

Prescribed training heart rate range | Achieved training heart rate range | Average RPE | Able to Self Pace No ☐ Yes ☐

Adaptations/limitations | Cardiac symptoms during exercise: please specify

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Home Exercise Programme: Frequency | Intensity | Time | Type

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

Important Notice

At time of transfer this patient: is clinically stable ☐ | concords with prescribed medication ☐ | is NOT awaiting further follow up or treatment ☐

is awaiting further follow up or treatment ☐ | Please specify

Cardiac Rehabilitation Professional Signature

Signature | Date

Email

Name | Job Title

Contact Address | Tel no.