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					

Current Cardiovascular Event

Most Recent Cardiovascular Event		Date	
Details			
Complications			

Current Angina (please tick) Yes No

Date of Onset		Details of Angina	
Triggers			

Relieved by GTN Yes No Relieved by Rest Yes No Frequency of GTN

Arrhythmias (please tick) Yes No

Date of Onset		Details of Arrhythmias	

Devices ICD Pacemaker CRT Details/Settings

Heart Failure Yes No Date

NYHA Classification 1 2 3 4

Investigations

Echocardiogram Date LV Function Good Moderate Poor Ejection Fraction %

Other Investigations **Ongoing Investigations**

Cardiovascular History Prior to Above Event

If NO previous Cardiovascular History (please tick)

Other Medical History

Stroke **Epilepsy** **Claudication** **COPD/Asthma** **Musculoskeletal problems** **Neuro problems**

Diabetes Type 1 **Diabetes Type 2**

Other/ Comments

Patient Name

Medication

Please tick those currently taken:

ACE Inhibitor | Alpha Blocker | Angiotensin II Receptor Blocker | Anti-arrhythmic | Specify type

Antiplatelet | Specify type | Aspirin | Beta Blocker

Calcium Channel Blocker | Specify type | Diuretic | DOAC/NOAC | GTN Spray/Tablets | Insulin

Ivabradine | Lipid Lowering Medications | Specify type | Metformin | Nitrate

Potassium Channel Activators | Sacubitril / Valsartan | SGLT2 Inhibitors | Warfarin | Other Medications

CVD 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 | Family History of CVD

Core Rehab Exercise Status

Date Started | Date Completed | Number of Exercise Sessions Attended

Mode: | In-person | Remote | Hybrid | 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 | METS Achieved | HR Achieved | %HRR

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

Home Exercise Programme / Exercise related goals

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

Verbal Consent given by Patient

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

Cardiovascular Rehabilitation Professional Signature

Signature | Date

Email

Name | Job Title

Contact Address | Tel No.