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**CARDIAC REHABILITATION REFERRAL FORM**

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

**DATE OF REFERRAL:**

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| --- | --- |
| Patient Details  Name:  Address:  Postcode:  D.O.B: Age:  Telephone Home:  Telephone Mobile:  NHS Number | Referrers Details  Name and Profession:  Surgery/Department:  Postcode:  Telephone: |
| **REASON FOR REFERRAL & DATE OF EVENT**  Inclusion criteria: patients who have had an acute event/admission within the last 12 months  Please tick all that apply  STEMI NSTEMI  CABG PCI  HEART FAILURE  (please supply accompanying information)  VALVE SURGERY (please note from 1/12/19 we are accepting West Hampshire Valve patients) | **CURRENT MEDICATION**  Aspirin Clopidogrel  Beta Blocker Ace Inhibitor  Warfarin Statin  Diuretic Nitrate  GTN Anti Arrhythmic  Other (please specify) |
| **INVESTIGATIONS**  Echocardiogram  YES NO DATE  LV FUNCTION:  GOOD MODERATE POOR | **PAST MEDICAL HISTORY**  Please tick all that apply  COPD/ASTHMA STROKE/TIA/CHD  HYPERTENSION HYPERLIPIDEAMIA  EPILEPSY MSK PROBLEMS  Other (please specify) |

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