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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 DetailsName: 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 monthsPlease tick all that applySTEMI NSTEMICABG PCIHEART FAILURE (please supply accompanying information) VALVE SURGERY (please note from 1/12/19 we are accepting West Hampshire Valve patients) | **CURRENT MEDICATION**Aspirin ClopidogrelBeta Blocker Ace InhibitorWarfarin StatinDiuretic NitrateGTN Anti Arrhythmic Other (please specify)   |
| **INVESTIGATIONS**EchocardiogramYES NO DATELV FUNCTION:GOOD MODERATE POOR | **PAST MEDICAL HISTORY** Please tick all that applyCOPD/ASTHMA STROKE/TIA/CHD HYPERTENSION HYPERLIPIDEAMIAEPILEPSY MSK PROBLEMSOther (please specify) |

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