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 ☐ 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
Aspirin	Beta Blocker	Calcium Channel Blocker	Name
Clopidogrel / Prasugrel / Ticagrelor	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 | Peak METS | Peak HR | %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.