BACPR Transfer Form



Patient's Name					Telephone number				
Address									
	Postcode								
Age		Date of birth		Er	nail				
Emergency Contact Number			Name			Relations	hip		
GP				1	Telephone Number				
Surgery name									
Address									
	Postcode								
Current Ca	ardiac E	vent							
Most Recent Cardiac Event					Date				
Details									
Complications									
Cardiac Hi	istory p	rior to above eve	nt						
-		tory (please tick)							
Please tick those a	applicable be	elow for all previous events	giving dates where						
STEMI Dat									
Unstable Angina	Date Date Date Date Date Date Date Date								
Valve	Repair Replacement Date Cardiac Arrest Date								
Heart Failure									
Other									
Current Angina (p	olease tick)	Yes No							
Date of onset	Details of angina								
Triggers					Relieved b	y rest or GTN	Yes No		
Arrhythmias (please tick) Yes No									
of onset		Details of arrhythmi	as						
Devices ICE	D Pac	emaker CRT	Details/Settings						
Medication	n								
Please tick those of	currently take	en:				Crocoifi			
ACE Inhibitor		Alpha Blocker	Angiotensin I Receptor Blo	cker	i-arrhythmic	Specify type			
Aspirin		Beta-blocker	Calcium Char Blocker	nnel Nan	ne				
Clopidogrel / Pr Ticagrelor	asugrel /	Diuretic	DOAC/NOAC	GT	N Spray/tablets		quency of of GTN		
Insulin		Ivabradine	Statin	Nitr	ate		assium Channel		
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 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 Ves Ves
Home Exercise Programme: Frequency Intensity Time 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.