Chronic Heart Failure/Angina
Cardiac Rehabilitation Referral Form

South West Yorkshire Partnership NHS Foundation Trust

Name: **Address:** **Post Code:** **Tel. No:**	**NHS No:** **D.O.B:** **Name/Address of G.P.** **Tel. No:**

Heart Failure ☐

Has the patient had an echocardiogram? No ☐ Yes ☐ If no referral will be rejected

Echo Findings: Mild ☐ Moderate ☐ Severe ☐ Please attach if available

NYHA classification: 1 ☐ 2 ☐ 3 ☐

Angina ☐

1. Has the patient had angina symptoms in the last 2 years? No ☐ Yes ☐ If no referral will be rejected

2. Has the patient been revascularised since diagnosis? No ☐ Go to question 4 Yes ☐

If Yes, has the patient had ongoing angina symptoms *since* revascularisation? No ☐ Yes ☐

If no referral will be rejected

4. Does the patient have GTN spray prescribed? No ☐ Yes ☐ If no referral will be rejected

Past Medical History

Medication

Any known drug allergies

Mobility Level:

Fully Independent ☐

Uses a walking aid ☐ Please specify:

Requires a wheelchair ☐

Referred By: Date	
Signature	Print Name
Designation	Contact Details

Please Email this referral form to swy-tr.CardiacRehab@nhs.net Tel: 01226 645430