Cardiac Rehabilitation Service Referral Form

(Post migration to INTS S1 unit version Nov 22)

South West Yorkshire Partnership NHS Foundation Trust

Date of referral……

PATIENT DETAILS	**Address:**
Name:	
D.O.B:	**Post Code:**
NHS Number:	**Tel. No:**

REFERRED BY **Name:** **Designation:** **Tel. No:**

REASON FOR REFERRAL / INCLUSION CRITERIA ***(Please tick the primary reason for referral as listed below):***

Patient aged 18+ and registered to a Barnsley GP practice and / or resident within the Barnsley geographical area ☐
If no, referral will be rejected.

Heart Failure ☐

Has the patient had an echocardiogram?

Yes ☐
If no, referral will be rejected.

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

NYHA classification:
1 ☐
2 ☐
3 ☐

Angina ☐

a) Has the patient had angina symptoms in the last 2 years?

Yes ☐
If no, referral will be rejected.

b) Has the patient been revascularised since diagnosis?

No ☐ Go to question c).
Yes ☐

If Yes, has the patient had ongoing angina symptoms since revascularisation?

Yes ☐
If no – referral will be rejected.

c) Does the patient have GTN spray prescribed?
Yes ☐
If no, referral will be rejected.

Recent Surgery/Procedure ☐

Please list the surgical procedure undertaken:

Discharge letter accompanying the referral?

Yes ☐

Acute Myocardial Infarction ☐

STEMI ☐
NON-STEMI ☐
ACS ☐
Other ☐

Cardiac advice booklet given to patient:

Yes ☐
No ☐

PAST MEDICAL HISTORY:

MEDICATIONS / ANY KNOWN DRUG ALLERGIES:

MOBILITY LEVEL:

Fully Independent ☐ Uses a walking aid ☐ Requires a wheelchair ☐ Other (please specify below):

E-mail completed referrals to: rightcarebarnsleyintegratedspa@swyt.nhs.uk

E-mail completed referrals to: rightcarebarnsleyintegratedspa@swyt.nhs.uk