Queensland Government

Statewide Cardiac Rehabilitation Referral Form

Facility: .....

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F ☐ I

***PLEASE ATTACH DISCHARGE SUMMARY FOR SITES OUTSIDE QUEENSLAND HEALTH**

Client details

Indigenous status: ☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Neither ☐ Not stated/Unknown

South Sea Islander status: ☐ Yes ☐ No ☐ Not stated/unknown

Interpreter required: ☐ Yes ☐ No Language: .....

Origin of Referral: ☐ Inpatient ☐ Outpatient Discharge date (if inpatient): / /

Medicare registered: ☐ Yes ☐ No ☐ Unknown Medicare number: .....

GP Details: Surname: ..... First name: .....

Clinic: .....

Diagnosis/procedure details

Diagnosis: ☐ STEMI ☐ NSTEMI ☐ Stable Angina ☐ Unstable Angina
☐ CHF ☐ Arrhythmia ☐ Valvular disease ☐ Other → _____

→ If STEMI OR NSTEMI: Troponin _____ug/L OR ng/L CK: _____U/L Date collected: / /

Most recent procedure: ☐ PCI ☐ Angiogram ☐ CABG ☐ Valve replacement/repair
☐ PPM/CRT-P/CRT-D/ICD ☐ Other:.....

Date of procedure: / /

Diagnosis/episode details:

Past medical history (including previous cardiac history):

Drug allergies

☐ Yes ☐ NKDA

Comments:

Angina/chest discomfort/CCS

Angina / cardiac symptoms? ☐ Yes ☐ No

If Yes to above: CCS score: ☐ I ☐ II ☐ III ☐ IV
Do you have a chest pain action plan? ☐ Yes ☐ No

Heart failure

Do you have heart failure? ☐ Yes ☐ No

If Yes to above: Have you experienced orthopnoea? ☐ Yes ☐ No
If Yes to above: Have you experienced PND? ☐ Yes ☐ No
If Yes to above: Have you been diagnosed with obstructive sleep apnoea? ☐ Yes ☐ No
If Yes → On CPAP? ☐ Yes ☐ No
If Yes to above: NYHA class: ☐ I ☐ II ☐ III ☐ IV ☐ N/A
If Yes to above: Do you have an action plan? ☐ Yes ☐ No

Ejection fraction

Ejection fraction: ☐ Tested ☐ Not tested
If tested: → Ejection fraction: _____% →Date measured: / /
→ Method: ☐ Angio LV gram ☐ Echocardiogram ☐ Other

v5.00 - 04/2020
SW781

STATEWIDE CARDIAC REHABILITATION REFERRAL FORM

Queensland Government

Statewide Cardiac Rehabilitation Referral Form

Facility: .....

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F ☐ I

Issues or concerns

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

Referral Pathway

Patient consented to CR ☐ Yes ☐ No

☐ **Refer to Queensland Health program**

☐ **Refer to external program (outside QH)**

Program location:
- ☐ Private (within QLD)
- ☐ Interstate
- ☐ Overseas

Receiving CR Program name: .....

Declined or Unsuitable Referrals

☐ Patient Declined:
- ☐ Client elects to self manage
- ☐ No available transport
- ☐ Family commitments
- ☐ Excessive wait times
- ☐ Program delivery times unsuitable
- ☐ Program length
- ☐ Other, Specify.....

.....

☐ Clinically unstable or inappropriate:
- ☐ Physical incapacity
- ☐ Mental incapacity
- ☐ Aged care resident
- ☐ Palliative care
- ☐ Rehab not required
- ☐ Local exclusion criteria
- ☐ Other, Specify.....

.....

☐ Client returned to work

☐ Ongoing Investigations

☐ Operational reasons

☐ Other, specify

.....

.....

.....

.....

.....

Referrer details

Name _____ Signature_____ Designation: _____

Contact no: _____ Referral date: / /