

		CARDIAC REHABILITATION PHASE II - REFERRAL	
SUNSHINE COAST – WIDE BAY HEALTH SERVICE DISTRICT BUNDABERG HOSPITAL, COMMUNITY ADULT HEALTH		PHONE: 41502731 FAX: 41502763	
Surname:		Given Names:	
Date of Birth:		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Permanent Residential Address:			
Postal Address: (If different to above)			
Phone: (H):		(W):	Mobile:
DOES THIS PERSON HAVE ANY OF THE EXCLUSION CRITERIA LISTED ON THE REVERSE SIDE OF THIS FORM? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, THIS PERSON IS UNSUITABLE FOR THIS PROGRAM			
Principal Cardiac Event/Procedure		Date	Past History and Co-morbidities
<input type="checkbox"/> ACS <input type="checkbox"/> STEMI <input type="checkbox"/> NON STEMI			
<input type="checkbox"/> Coronary Artery Bypass Graft			
<input type="checkbox"/> Valve Surgery <input type="checkbox"/> Aortic <input type="checkbox"/> Mitral			
<input type="checkbox"/> Other (list)			
ALLERGY /ADVERSE DRUG REACTION:			
Test Results – please attach copies of the following			
<input type="checkbox"/> Angiogram		<input type="checkbox"/> Lipid Profile	
<input type="checkbox"/> Stress Test		<input type="checkbox"/> 12 Lead ECG post event	
<input type="checkbox"/> Nuclear Stress		<input type="checkbox"/> HBA1c	
<input type="checkbox"/> Echocardiogram		<input type="checkbox"/> Medication list	
<input type="checkbox"/> Please include any other relevant results			
Risk Factors for Cardiovascular Disease			
<input type="checkbox"/> Previous IHD History		<input type="checkbox"/> Inactivity	<input type="checkbox"/> Overweight
<input type="checkbox"/> Family History		<input type="checkbox"/> Stress	<input type="checkbox"/> HRT
<input type="checkbox"/> High Blood Lipids		<input type="checkbox"/> Diabetes <input type="checkbox"/> Insulin	<input type="checkbox"/> Smoking
<input type="checkbox"/> High Blood Pressure		<input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2	<input type="checkbox"/> Current <input type="checkbox"/> Previous
Please attach any additional relevant information			
Referring Doctor: (Insert Practice details)		Contact No:	
Signature:		Date:	

SEE EXCLUSION CRITERIA ON REVERSE OF PAGE

ABSOLUTE EXCLUSION CRITERIA

(IF ANY OF THE BELOW APPLY THE PERSON IS NOT SUITABLE FOR PHASE II CARDIAC REHABILITATION)

- Unstable angina
- Uncontrolled diabetes
- Is not independently mobile
- Unable to walk continuously on flat ground for a minimum of 5 minutes
- Musculoskeletal disorders affecting mobility and ability to exercise
- Other metabolic disorders, such as acute thyroiditis, hypo-or hyperkalaemia, hypovolemia, etc.
- Resting Systolic BP >160mmHg or resting Diastolic BP >100mmHg
- Orthostatic blood pressure drop of >20mmHg with symptoms
- Critical systemic illness or fever
- Third degree AV Block (without pacemaker)
- Uncontrolled sinus tachycardia (>120bpm)
- Uncontrolled atrial or ventricular dysrhythmias
- Active pericarditis or myocarditis
- Current pleural effusion
- New CCF or CCF complicating recovery
- Recent embolism
- Thrombophlebitis
- Resting ST displacement (>2mm)
- Terminal illness or other disease that may prevent ability to benefit (e.g. advanced dementia, advanced MS or kidney disease, uncontrolled clinical depression)
- Severe aortic/valvular stenosis
- Cannot self care
- Client refusal
- Physician/GP refusal

Cardiac Rehabilitation is a six week exercise program. Participants will attend for two 60 minute exercise sessions per week and one education session per week (ie. ATTENDANCE IS A TOTAL OF TWICE A WEEK).

PLEASE NOTE:

**PEOPLE WITH HEART FAILURE (BOTH SYSTOLIC AND HEART FAILURE WITH PRESERVED SYSTOLIC FUNCTION) CAN BE REFERRED TO THE HEART FAILURE MANAGEMENT PROGRAM.
Phone: 41502797 Fax: 41502763**