

Wharfedale General Hospital Cardiac Club

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Date:

Dear Dr

Membership Application for [insert name of applicant].....

The above named has applied to take part in Phase 4 Cardiac Rehabilitation exercise classes as a Member of the Wharfedale General Hospital Cardiac Club (WGHCC).

Our procedures require that we are satisfied that any applicant is medically able to exercise and therefore to allow the applicant to exercise and to provide the correct support, our Instructors need to be aware of the relevant medical history and medication.

We would be grateful if you could please confirm that this applicant is suitable to exercise and complete the enclosed, standard BACR CHD GP EXERCISE REFERRAL FORM in support of this?

WGHCC is specifically for people who are rehabilitating from a cardiac event, or for those who wish to exercise for preventative reasons. Classes are held under the supervision of Instructors qualified to BACPR Phase 4 REPS level 3 or 4 or who hold similar professional standard qualifications. Further information on WGHCC can be found on our website.

Thank you for helping our potential new member towards exercise classes and a healthier lifestyle.

Yours Sincerely

On behalf of Wharfedale General Hospital Cardiac Club

D Farrow
Chairman/Secretary

CHD GP EXERCISE REFERRAL FORM



To be completed by the Referring Doctor or designated health professional

Please print clearly

Patient Details

Name: _____
 Address: _____

 Postcode: _____ D.O.B. _____ Age: _____
 Telephone Home: _____
 Telephone Work: _____

Referrer's Details

Name & Profession: _____
 Surgery / Department: _____
 Address: _____

 Postcode: _____
 Telephone: _____

Cardiac History

✓ if applicable

MI: Date: _____ Heart Failure: ICD: Pacemaker:
 Angioplasty / Stent: Date: _____ Other Event/s: _____ Date: _____
 CABG: Date: _____
 Current Angina: At Rest: On Exertion: GTN: Current Dyspnoea: Arrhythmias:

✓ if prescribed

Current Medication

(attach prescription list if available)

Aspirin <input type="checkbox"/>	Beta blocker <input type="checkbox"/>	Ace Inhibitor <input type="checkbox"/>	Statin <input type="checkbox"/>
Clopidogrel <input type="checkbox"/>	Warfarin <input type="checkbox"/>	Diuretic <input type="checkbox"/>	Nitrate <input type="checkbox"/>
Anti-arrhythmic <input type="checkbox"/>	Calcium channel blocker <input type="checkbox"/>	GTN <input type="checkbox"/>	Other: _____

Investigations (if available)

ETT: Yes No Date: _____ LV Function:
 Result: _____ Good Moderate Poor

Current Status - CHD Risk Factors

Resting BP _____ Resting Heart Rate _____ BMI _____ Stable Type 1/Type 2 Diabetes
 Raised Cholesterol Physically Inactive Smoker Excess Alcohol Stress

Past Medical History

✓ if applicable, please supply dates & details as far as possible

COAD / Asthma Epilepsy Hypertension Claudication
 CVA / Neuro. Problems Ortho/musc. skeletal problems Details: _____
 Other considerations: _____

IMPORTANT NOTICE

- The patient exhibits no contraindication to exercise (as indicated on the protocol)
- The patient is clinically stable
- The patient is compliant with medication
- The patient is awaiting / not awaiting further medical or surgical treatment (see protocol)

REFERRER'S SIGNATURE: _____

Print Name: _____ Date: _____

GP's signature (if different from above): _____

Print Name: _____ Date: _____

PATIENT INFORMED CONSENT

I agree for the above information to be passed onto 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 also inform the instructor of any changes in my medication, the results of any investigations or treatment.

PATIENT SIGNATURE: _____

Print Name: _____ Date: _____