# Cardiac Rehabilitation Referral Request

**Tel: 4162548 Email: cardiacrehabref@stjames.ie**

NB: Please support this referral with all relevant procedural documentation
Medications list ☐ Angio ☐ Surgical Notes ☐ Echo ☐ ECG ☐

Patient Name: _____**DOB**: _____MRN: _____

Patient Address:

_____

_____

_____ **Phone**: _____

Source of Referral : (Hospital/GP/OPD Clinic) _____ NTPF Scheme Y ☐ N ☐

**PRESENTING COMPLAINT** *(Please Tick)*

| | | | |
|---|---|---|---|
| STEMI ☐ | NSTEMI ☐ | STABLE ANGINA ☐ | |
| PCI ☐ | TAVI (*Percutaneous*) ☐ | Other/Specify | |
| CABG ☐ | Valve surgery☐ Please specify | | |
| Other Heart Surgery☐ - specify: | | | |
| CCF (*Criterion: optimal HF therapy > 4weeks*) | IDIO ☐ | IHD ☐ | HFPeF ☐ |
| Most Recent EF% | PPM | ICD Status | CRTd Status |

**OTHER PAST MED/SURG HX**

**RISK FACTOR PROFILE**

| | | | | | |
|---|---|---|---|---|---|
| Fhx | Dyslipidaemia | Cigs? Never ☐ Current ☐ EX ☐ Recent Ex *(<6/12)* ☐ | | */per day* | |
| HTN | ↑ BMI | T2DM | Stress | Bereave | Gout |
| Sedentary? | Activity Profile | | C2H5OH (Units/Wk) | | |

**Comments:**

**Referrer Name:** _____

**Discipline:** Doctor ☐ Nurse ☐ Rehab Co-ordinator ☐ Other ☐ _____

**Contact details:**_____