Cardiac Rehabilitation Service Referral Form

Please complete this form in full as it will be assessed according to the information you provide. Incomplete forms may be returned for more information to be provided.

Patient is required to attend a community-based clinic setting for cardiac rehabilitation assessment, service not suitable for housebound patients.

Completed forms are to be submitted via an nhs.net email account to: access@ecchcic.nhs.uk
For support please contact 01493 809977.

Referral Criteria	
Inclusions: Confirmed Diagnosis ONLY Myocardial Infarction (MI) Non-ST Elevation MI (NSTEMI) ST Elevation MI (STEMI) Percutaneous Coronary Intervention (PCI) Coronary Artery Bypass Graft (CABG) Spontaneous coronary artery dissection (SCAD) Takotsubo cardiomyopathy Stable heart failure reduced ejection fraction (HFrEF) *(please refer via reach heart failure referral form)*	**Exclusions:** Angina Transplant Heart failure Left ventricular assist devices Intraventricular Cardiac Defibrillator (ICD) Transcutaneous aortic valve intervention (TAVI) Arrhythmia Heart Valve Surgery

Patient Details		**Patient's Emergency Contact Details**	
NHS number:	<NHS number>	Relationship:	<Relationships>
Date of birth:	<Date of Birth>		
Title:	<Patient Name>	Name:	<Relationships>
Surname:	<Patient Name>		
Forename(s):	<Patient Name>		
Address:	<Patient Address>	Address:	<Relationships>
Postcode:	<Patient Address>		
Telephone no:	<Patient Contact Details>	Telephone no:	<Relationships>
Mobile no:	<Patient Contact Details>	Mobile no:	<Relationships>

GP Details			
GP Name:	<GP Name>	Surgery:	<GP Details>
Contact No:	<GP Details>		
Referrer Details			
Name:	<Sender Name>	Job Title:	
Organisation:	<Organisation Details>	Contact No:	<Sender Details>
Date of referral:	<Today's date>		

If the service user requires an interpreter, please specify language:	
Accessible Information Standards	
Does the service user have additional needs related to:	Please specify below as applicable.
Vision	
Hearing	
Speech	
Other communication difficulties	

Has patient consented to referral?	If no, please give reason:
☐ Yes / No ☐	

Medical Information	
Diagnosis*	
Procedures undertaken*	

Please attach to referral:

- Discharge summary
- ECHO results (if available)

If patient has had ST Elevation Myocardial Infarction (STEMI), Non-ST Elevation Myocardial Infarction (NSTEMI) or Elective Percutaneous Coronary Intervention (PCI), please attach:

- Discharge summary
- GP procedure report
- Lab procedure summary

Relevant medical history, please add as attachment if necessary:

Current Medication:

***Accepted Abbreviations**

MI - Myocardial Infarction
STEMI - ST Elevation Myocardial Infarction
NSTEMI - Non-ST Elevation Myocardial Infarction
PCI - Percutaneous Coronary Intervention
CABG - Coronary Artery Bypass Graft)
TAVI - Transcutaneous Aortic Valve Intervention)