`NHS Tayside Cardiac Rehabilitation

Heart Failure Referral Form

Patient Name:					**D.O.B. / CHI:**	
Patient Address:					**G.P. Practice:**	
					First Contact Name and Number:	
Patient Telephone Number:					**DH**	**Name** / **Dose**
CHF Aetiology:					Warfarin	
IHD					Beta Blocker	
Hypertension					ACE-Inhibitor	
Cardiomyopathy					GTN	
Valvular					Loop Diuretic	
Unknown					Thiazide	
Other					Diuretic	
Cardiac History / Investigations:					ARB	
ECHO: Y / N	Date of ECHO:				**Others:**	
LVF: Preserved / mild / moderate /severe dysfunction						
New York Class:	1	2	3	4	**PMH:**	
Angiogram: Y / N	Date of Angio:				COPD / Asthma	
Result of Angiogram:					MI /CVA / TIA	
					CRF	
Arrythmia: Y / N					PVD	
Current Symptoms:					Diabetes – Type I / Type II	
Fatigue:					Hypertension	
Dyspnoea:					Other:	
Orthopnoea:						
PND Frequency:					**Maximum comfortable walking distance:**	
Oedema:					**Other exercise:**	
Pain:						
Referral for exercise assessment in: **Ninewells / Stracathro / Arbroath Infirmary / PRI / Home Visit /**						
Name of Specialist Heart Failure Nurse:					Date of referral:	
Signature of Specialist Heart Failure Nurse:						