

**CARDIAC REHABILITATION PHASE 1V INFORMATION SHEET**



Name _____	GP Dr _____
Address _____ _____	Tel no _____
Tel no _____	Emergency Contact _____ _____
Age _____ DOB _____	Tel no _____

**CURRENT CARDIAC STATUS**

Diagnosis _____ Date _____ Complications _____ Y/N ETT Protocol _____ Full/Modified Bruce Result -ve/+ve _____ Date _____ Completed _____ mins _____ Stopped because _____ Angiogram _____ Y/N Date _____	Angioplasty/Stent _____ Y/N Date _____ BP _____ Pulse _____ reg/irreg LV Function _____ Good/Moderate/Poor Assoc Heart Failure _____ Y/N Mild/Moderate Current Angina (post MI/CABG) _____ Y/N Rest Y/N _____ Exertion Y/N _____ Incidence _____ GTN Y/N _____ Comments _____
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**PAST MEDICAL HISTORY**

Angina <input type="checkbox"/>	Diabetes <input type="checkbox"/>	Epilepsy <input type="checkbox"/>
MI <input type="checkbox"/>	CVA/Neuro <input type="checkbox"/>	COAD/Asthma <input type="checkbox"/>
Angioplasty <input type="checkbox"/>	Ortho/musc.skeletal <input type="checkbox"/>	_____
Other Cardiac <input type="checkbox"/>	CABG <input type="checkbox"/>	Other considerations _____
Surgery <input type="checkbox"/>		_____
Hypertension <input type="checkbox"/>	Claudication <input type="checkbox"/>	

**CURRENT DRUGS (please tick)**

Asprin <input type="checkbox"/>	Beta Blocker <input type="checkbox"/>	ACE Inhib <input type="checkbox"/>	Nitrate <input type="checkbox"/>
Diogoxin <input type="checkbox"/>	Warfarin <input type="checkbox"/>	Diuretic <input type="checkbox"/>	"Statin" <input type="checkbox"/>
Anti-arryth <input type="checkbox"/>	CC block <input type="checkbox"/>	Other _____	

## SECONDARY PREVENTION

Known : FH       IDDM/NIDDM       CHD History

Risk Factors    Pre MI/CABG    Comp phase III    Risk Factors    Pre MI/CABG    Comp phase III

Smoking	<input type="checkbox"/>	<input type="checkbox"/>	Excess Alcohol	<input type="checkbox"/>	<input type="checkbox"/>
Raised Chol	<input type="checkbox"/>	<input type="checkbox"/>	Sedentary	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	Stress	<input type="checkbox"/>	<input type="checkbox"/>
Overweight	<input type="checkbox"/>	<input type="checkbox"/>			

Agreed rehab goals Y/N Compliant with medication Y/N.

## PHASE III GRADUATION INFORMATION

Date of entry to phase III \_\_\_\_\_ Coped well Phase III ex sessions Y/N \_\_\_\_\_

Date of discharge to phase IV \_\_\_\_\_ Symptomatic Y/N \_\_\_\_\_

No. of exercise sessions attended \_\_\_\_\_ Phase III indiv. Ex Assessment attached Y/N

Comments.. \_\_\_\_\_  
\_\_\_\_\_

Av. Resting HR reg/irreg \_\_\_\_\_ bpm

Regular walk Y/N    Dist    Time

Training HR reg/irreg \_\_\_\_\_ bpm

Other activities \_\_\_\_\_

Working @ METs/RPE \_\_\_\_\_

BP on completion prog. \_\_\_\_\_

Exercise assessment on completion of Phase III

Resumed work Y/N      Retired Y/N

Y/N Date \_\_\_\_\_

Result \_\_\_\_\_

Occupation \_\_\_\_\_

## IMPORTANT NOTICE

Please identify if patients is awaiting further medical/surgical treatment after completion of Phase III in which case transition to phase IV may need to be delayed or exercise limited pending

e.g.

- Angiogram
- Angioplasty
- Surgery
- Cardiology review / Investigations

Date of Phase III completion \_\_\_\_\_

I AGREE FOR THE ABOVE INFORMATION TO BE PASSED ONTO THE PHASE IV 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 SYMPTONS. I WILL ALSO INFORM THE INSTRUCTOR OF ANY CHANGES IN MY MEDICATION, THE RESULTS OF ANY INVESTIGATIONS OR TREATMENT.

PATIENT SIGNATURE \_\_\_\_\_

PLEASE PRINT NAME AND ADDRESS

CR PROFESSIONAL SIGNATURE \_\_\_\_\_

Date \_\_\_\_\_