

# Patient registration

for your doctor to complete

## PATIENT to complete

I (the patient) give consent to **HeartBeat** staff at the Canning Division of General Practice to access my medical records to assist with treating my heart disease and for the evaluation of the heart disease prevention process. All information provided is treated as strictly confidential and will not be released unless required to do so by law. I also give consent to **HeartBeat** staff to call for an ambulance should medical assistance be required.

Participant signature \_\_\_\_\_ Date \_\_\_\_\_

## Personal details

Name \_\_\_\_\_  
Date of birth \_\_\_\_\_  
Address \_\_\_\_\_  
\_\_\_\_\_  
Phone (a/h) \_\_\_\_\_  
Emergency Contact Name \_\_\_\_\_  
Emergency Contact Phone \_\_\_\_\_

## Referring GP – (name, address and phone)

## Cardiac history – Results of known cardiac investigations/procedures and events (please provide dates and as much detail as possible)

Exercise Stress Test \_\_\_\_\_  
Coronary Angiogram \_\_\_\_\_  
LV Function \_\_\_\_\_  
Cardiac Surgery \_\_\_\_\_  
Cardiac events \_\_\_\_\_  
Other, please specify \_\_\_\_\_

## Test results. Date last taken

Height \_\_\_\_\_ m      Blood pressure \_\_\_\_\_ mm Hg      **Care plan** developed?  
Weight \_\_\_\_\_ kg      Total cholesterol \_\_\_\_\_ mmol/L       Yes       No

## Important information about the Exercise Classes

Community Physiotherapy Services exercise programs are run by Physiotherapists in the community. As they are conducted in a group setting, a certain **minimum level of mobility is required**. In order to place your patient in the most appropriate class, and in the interests of safety, we request the following information.

The client's progress will be monitored by the physiotherapist at the class, to ensure suitability.

For enquiries contact a Senior Physiotherapist at Community Physiotherapy Services phone 9224 1783.

**To register in the Exercise Class, please complete the Medical Profile overleaf**

# Patient Medical Profile for Exercise Class

**Cardiac history**

<b>Risk factor assessment – (please tick)</b>		<b>Cardiac medications – (please tick)</b>	
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Overweight/Obese	<input type="checkbox"/> Anti-arrhythmics	<input type="checkbox"/> Ca channel blocker
<input type="checkbox"/> Hyperlipidemia	<input type="checkbox"/> Diabetes Type 1	<input type="checkbox"/> Anti-coagulants	<input type="checkbox"/> Beta blockers
<input type="checkbox"/> Physical inactivity	<input type="checkbox"/> Diabetes Type 2	<input type="checkbox"/> Anti-platelets	<input type="checkbox"/> ACE inhibitors
<input type="checkbox"/> Current smoker	<input type="checkbox"/> Family history*	<input type="checkbox"/> Diuretics	<input type="checkbox"/> Angiotensin II antagonists
<input type="checkbox"/> Ex smoker	*premature death 65 yrs	<input type="checkbox"/> Lipid lowering	<input type="checkbox"/> Nitrates
		<input type="checkbox"/> Digitalis	<input type="checkbox"/> Vasodilators
		<input type="checkbox"/> Other medications _____	

**Clinical indices that may influence participation in the community setting (tick those that apply)**

<input type="checkbox"/> Poor exercise tolerance < 300m	<input type="checkbox"/> 3 vessel or left main disease
<input type="checkbox"/> Anti-arrhythmic(s) for complex ventricular arrhythmia	<input type="checkbox"/> Angina post MI
<input type="checkbox"/> Cardiogenic shock or HF post MI	<input type="checkbox"/> Survivor of cardiac arrest
<input type="checkbox"/> Left ventricular EF < 30%	
<input type="checkbox"/> Other, please specify _____	

If any of these comorbidities applies, we will call you to discuss class placement.

**Other medical conditions**

<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Visual Impairment
<input type="checkbox"/> Joint or Spinal problems (please detail)	_____
<input type="checkbox"/> Respiratory disease (please detail)	_____
<input type="checkbox"/> Other relevant conditions (please detail)	_____
<input type="checkbox"/> Recent surgery (please detail)	_____

**Functional assessment**

**The client**

Can stand with no aid     Walk with no aid     Sit/ stand with no aid     Chair-floor-chair

Has been assessed / treated by a physiotherapist?

Has been given a home exercise program?

What other services will this patient be accessing? \_\_\_\_\_

**Transport**

For transport assistance, please contact Commonwealth Carelink Centres on 1800 052 222.

GP signature \_\_\_\_\_ Date \_\_\_\_\_