

APPENDIX A - TRANSFER TO CRP2 HOME-BASED EXERCISE SESSIONS CHECKLIST**PATIENT DETAILS**

HC# _____ Name: _____ Risk Cat: _____ Current Group: _____

REVIEWER

Name: _____ Corporation Number _____

TRANSFER DETAILS:

1. Number of completed sessions:
2. Proposed Transfer date:
3. Transfer to Program Type:
 - a. Home Unsupervised and Monitored by remote ECG telemetry
 - b. Home Supervised via Telehealth platform and Monitored by remote ECG telemetry
 - c. Home Supervised via Telehealth platform and Monitored by RPE-only
4. Timing:
 - a. MW0730 MW0900 MW1030 MW1200 MW1330 MW1600 MW1730
 - b. STT0730 STT0900 STT1030 STT1200 STT1330 STT1600 STT1730
5. Location: Home Work Home Gym Work Gym
(Public areas such as parks or public gyms are not allowed)
6. Equipment available: None Treadmill Cycle Other:

PATIENTS CLINICAL STATUS:

1. Eligible to exercise without ECG monitoring? Yes No
 - a. No History of Cardiac Arrest outside the context of ACS
 - b. No history of v-tach or other life-threatening arrhythmia
 - c. LVEF \geq 30%
 - d. No cardiac symptoms
2. Eligible for Home Program? Yes No
 - a. No complex arrhythmias at rest or exercise
 - b. No significant ST depression / ECG changes on exercise
 - c. No other investigations pending (i.e Holter ECG, Labs,...)
 - d. No Falls Risk identified
3. Is the patient Diabetic? Yes No
 - a. Is his/her blood sugar well controlled? Yes No
 - b. Any episodes of exercise related hypo/hyper glycaemia reported? Yes No
 - c. Does the patient have a Glucometer at home? Yes No
 - d. Comments: _____
4. Is the patient Hypertensive? Yes No
 - a. Is his/her BP well controlled? Yes No
 - b. Any episodes of exercise related hypo/hypertensive responses? Yes No
 - c. Does the patient have a Blood Pressure machine at home? Yes No
 - d. Comments: _____
5. Any recent changes to related interventions?
 - a. Recent change in medications Yes No

TRANSFER DECISION AT TEAM CONFERENCE (Date _____ Physician Present _____)

- APPROVED
- DENIED → Reason: _____
- POSTPONED → Plan: _____

COMPLETING THE TRANSFER:

1. Has the patient been thoroughly explained the HYCRP2-EP requirements? Yes No
2. Has the patient agreed to the transfer under the above conditions? Yes No
3. Has Telehealth application been installed? Yes No
4. Has remote ECG telemetry unit been assigned & checked for correct functioning? Yes No
5. Contact information:
 - Zone#: _____ Street#: _____ Building#: _____ Apt#: _____
 - Phone#: _____ Email: _____
6. Progress Note on Electronic Medical Record system completed: Yes No