NAME: : **Address:** **DOB:** **NHS No:**	Please tick if address is correct ☐	New address:

Serial No: xxxxx

BRHS (men) Record Review 2022

THE QUESTIONS ON THIS PAGE RELATE TO THE PERIOD FROM **1ST JULY 2020** TO PRESENT

YES NO

1 Is the above patient still registered with you? ☐ ☐

2 Has he **consulted** you since 1st July 2020? ☐ ☐

3 Was any consultation for a **new episode** of: (day, month, year)

***Myocardial Infarction** (MI) Heart attack, Coronary thrombosis	☐ ☐	Date: ……..*
***Acute Coronary Syndrome**	☐ ☐	Date: ……..*
Angina Exertional or stress related chest pain	☐ ☐	Date: ……
***Stroke** Cerebrovascular accident (CVA), cerebral thrombosis, haemorrhage embolism	☐ ☐	Date: ……..*
Transient Ischaemic Attack (TIA/ TCIA) Cerebrovascular disturbance (<24 hours); leaving no residual damage	☐ ☐	Date: ……
Diabetes (NIDDM Type 2 / IDDM Type 1)	☐ ☐	Date: ……
***Heart Failure** Congestive Cardiac Failure (CCF) or Left Ventricular Failure (LVF)	☐ ☐	Date: ……..*

Other Cardiovascular disease:

Peripheral Arterial Disease (PAD,PVD) Intermittent claudication, lower limb ischaemia	☐ ☐	Date: ……
Aortic Aneurysm- rupture, dissection	☐ ☐	Date: ……
***Deep Vein Thrombosis** (DVT) blood clot in the leg	☐ ☐	Date: ……..*
***Pulmonary Embolism** (PE) blood clot in the lung	☐ ☐	Date: ……..*

*** If Yes, please send a copy of the hospital letter or discharge summary**

YES NO

4 Has he been referred to a Consultant for any new cardiovascular condition? ☐ ☐ Date: ……

Diagnosis: ……..

5 Have any of the following procedures taken place: **YES NO**

Coronary Artery Bypass Graft (CABG)	☐ ☐	Date: ……
Coronary Angioplasty (PTCA) Percutaneous coronary angioplasty, balloon treatment. Insertion of stents ☐	☐ ☐	Date: ……

6 Has he had a Cancer diagnosis? ☐ ☐ Date: ……

Site: ……..

7 Has there been a diagnosis of: **YES NO**

COVID-19	☐ ☐	Date: ……
Atrial Fibrillation	☐ ☐	Date: ……
Dementia	☐ ☐	Date: ……

If yes, please give details of the type of dementia:

Vascular dementia ☐

Alzheimer's disease ☐

Other ☐ please give details ……..

Dementia type not known ☐

8 **Frailty** Has a frailty score been calculated? Yes, eFI score ☐ Yes, other score ☐ No frailty score calculated ☐

If yes, please provide details – enter **last** frailty score recorded in each year.

Date of Frailty Score	**Electronic *frailty* index (eFI)**	**Other** Frailty Assessment System		Do you consider this patient to be clinically frail?
Month / Year	**eFI Score**	Name of score	Grade/value	**YES NO NOT ASSESSED**
……../2020				☐ ☐ ☐
……../2021				☐ ☐ ☐
……../2022				☐ ☐ ☐

Signed …… Date:……..

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