Basic application form

for recognition as a new cardiovascular rehabilitation programme

**Name of the institution:**

**Address:**

 **ambulatory** **[ ]  stationary** **[ ]**

**Medical director:**

Volume of work:       %

Internist Yes [ ]  No [ ]

Cardiologist Yes [ ]  No [ ]

Training in cardiac rehabilitation Yes [ ]  No [ ]

If yes, please specify:

**Deputy:**

Volume of work:       %

Internist Yes [ ]  No [ ]

Vardiologist Yes [ ]  No [ ]

Training in cardiac rehabilitation: Yes [ ]  No [ ]

If yes, please specify:

**How many patients do you expect to treat in your institution per year?**

**- in the first 2 years:**

**- at medium/ long-term:**

**Programme duration/content:** **weeks**

 **number of sessions/ week**

**Staff (number)**

Medical doctor:

 Nurse:

Physiotherapist/exercise specialist:

 Dietician:

 Psychologist:

 Secretary:

 Others:

**Infrastructure:**

Gymnastic room Yes [ ]  No [ ]

 Swimming pool Yes [ ]  No [ ]

 Weight training room Yes [ ]  No [ ]

 Education room Yes [ ]  No [ ]

**Medical facilities:**

ECG Yes [ ]  No [ ]

Bicycle ergometre Yes [ ]  No [ ]

Treadmill Yes [ ]  No [ ]

 Echocardiography Yes [ ]  No [ ]

 Stress-Echo Yes [ ]  No [ ]

 Cardiopulmonary exercise testing Yes [ ]  No [ ]

 Pacemaker control Yes [ ]  No [ ]

 Holter ECG Yes [ ]  No [ ]

 24h-blood pressure measurement Yes [ ]  No [ ]

**Emergency equipment and concept**

Defibrillator available at all activities? Yes [ ]  No [ ]

Emergency equipment available? Yes [ ]  No [ ]

Availability of emergency concept? Yes [ ]  No [ ]

Repetitive CPR instruction of staff? Yes [ ]  No [ ]

* How many times per year?
* How is participation documented?

**Home many treatment units (exercise and counselling) are offered (total number of**

 **the programme)?**

**Duration of treatment unit?**      Min.

**Number of specific treatment units:**

Bicycle-/Treadmill-Training

Gymnastics

Strength training

Outdoor endurance activities

Relaxation sessions

Water gymnastics

Education sessions (total)

* Medical topics
* Nutrition councelling
* Psychosocial topics
* Smoking cessation

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**Statement of the SCPRS board:**

* Application received (date)
* Check by SCPRS board (date)
* Appraisal of the submission/ critical points:

* Conferral of provisional recognition (date)