**Active 4 Health Exercise Referral**

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| **East Dorset Exercise Referral**  **Contact:** Active 4 Health Lifestyle Coordinator  Moors Valley Country Park  Horton Road, Ashley Heath  Nr Ringwood, Dorset, BH24 2ET | **Copy 1:**  Please send to Lifestyle Coordinator | | **Copy 2:**  Printed Patient Copy | Participant ID |
| **Who can be referred?**  Patients with low, medium or high risk conditions can be referred onto the Active 4 Health programme whereby the Lifestyle Coordinator will signpost the patient into the most appropriate pathway to suit individual needs, interests and location. | | | | |
| **Health Professional: How do I refer?**   * Autofill patient details * Please ensure patient email address and telephone number are entered into the form * Type in reason for referral and any relevant medical information * Print 1 copy for the patient to sign and hand back to the health professional and email a scanned copy of the form securely to: [*active4health@dorsetcouncil.gov.uk*](mailto:active4health@dorsetcouncil.gov.uk) * Print 1 copy for the patient to retain | | **Patient: What do I do next?**   * Please contact the Active 4 Health team by emailing [active4health@dorsetcouncil.gov.uk](mailto:active4health@dorsetcouncil.gov.uk) with your details and the best time to call you, or call 01202 795 141 if you don’t have access to email. * Keep hold of your copy of the referral form. | | |
| **Active 4 Health services across Dorset**   * Active 4 Health includes a range of leisure centre, outdoor and community based activities such as walking/cycling groups, gym sessions, indoor and outdoor fitness classes, swimming, Chair Fit, hydrotherapy, specialist high risk classes etc. Based at:   *-Queen Elizabeth Leisure Centre -Verwood Lifestyle Hub*  *-Ferndown Leisure Centre -BH Live, Corfe Mullen*  *- Moors Valley Country Park (Green referral) -Community –Health Walks & Cycles, Accessible Cycling etc*  *- Purbeck Leisure Centre - more locations developing*   * 12 week exercise referral programme available at each site including 1-2-1 consultations with specialist exercise referral instructors who will design a personalised exercise plan to suit your individual health needs, goals and interests * Our exercise referral team have a range of Level 4 Specialisms for high risk patients; these include Cancer, Pulmonary, Stroke, Obesity and Diabetes, and Cardiac Phase 4. * **Concessionary rates apply at each site** | | | | |

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| **Date of Referral** (todays date) |  | | | |
| **PATIENT DETAILS** | | | **REFERRER DETAILS** | |
| **Full Name** | |  | **Full Name** |  |
| **Gender** | |  | **Profession**  i.e. GP, practice nurse, physio |  |
| **Date of Birth** | |  | **Practice** |  |
| **Address** | |  | **Address**  **Postcode** |  |
| **Postcode** | |  |
| **Home telephone number** | |  | **Telephone Number** |  |
| **Mobile number** | |  | **Registered GP name**  (if different from above) |  |
| **Email Address** | |  | | |

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| **Current Medication** | | | | | | | | |
| **Medication:** | | | | | | | |
| Acutes: |  | | | | | | |
| Repeats: |  | | | | | | |
| **MAIN REASON FOR REFERRAL:** Please do not refer anyone with absolute contraindications (see below) | | | | | | | | |
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| **MEDICAL INFORMATION:** Please provide all recent and relevant information on the patients’ health status including dates | | | | | | | | |
| **Blood Pressure** | |  | **BMI** |  | **Cholesterol** | |  | |
| **Sedentary lifestyle** | | |  | | | | | |
| **At risk of falls** (include falls history) | | |  | | | | | |
| **Hypertension/Hypotension** | | |  | | | | | |
| **Diabetes** | | |  | | | | | |
| **Coronary Artery Disease**  **\* Please fill out additional section below** | | |  | | | | | |
| **Respiratory** | | |  | | | | | |
| **Musculoskeletal** | | |  | | | | | |
| **Stroke/TIA/Brain injury**  **\* Please fill out additional section below** | | |  | | | | | |
| **Pre/Post Surgery** | | |  | | | | | |
| **Cancer** | | |  | | | | | |
| **Mental Ill Health** | | |  | | | | | |
| **Autoimmune/neuromuscular** | | |  | | | | | |
| **Neurological** | | |  | | | | | |
| **Chronic Fatigue/ME** | | |  | | | | | |
| **Epilepsy** | | |  | | | | | |
| **Other** | | |  | | | | | |
| **Any additional comments that may affect exercise:** | | |  | | | | | |
| **Referrer’s Declaration:**  In my clinical opinion, the above named patient is capable of undertaking a suitable exercise programme under the Active 4 Health referral programme. | | | | | | Signature:  Date: | | |
| **Patient’s Declaration:**  I agree for the above information to be passed onto the Active 4 Health Lifestyle Coordinator. I also give my consent to be contacted by the Lifestyle Coordinator. | | | | | | Signature:  Date: | | |

**For Patients with Coronary Artery/Heart Disease ONLY**

**MUST HAVE COMPLETED PHASE 3 CARDIAC REHAB**

*Please tick box if applicable and provide dates where necessary*

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| **Phase 3 Cardiac Rehab complete?** | **No**  **Yes**  **Date of discharge:** | |
| **Heart Failure** |  | |
| **Myocardial Infarction** |  | |
| **Angioplasty / Stent** |  | |
| **Coronary Artery Bypass Surgery** |  | |
| **Implantable Cardioverter-Defibrillator (ICD)** |  | |
| **Current Dyspnoea** |  | |
| **Current Angina** | **At rest**  **On exertion** | |
| **Arrhythmias** | **Bradycardia**  **Tachycardia** | |
| **Other event(s)** |  | Date: |
| **Other event(s)** |  | Date: |
| **Information on any investigations undertaken** |  | |

**For Patients who have had a Stroke ONLY**

*Please tick box if applicable and provide dates/comments where necessary*

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| **NHS Rehabilitation service attended?** | | **No**  **Yes**   **Date of discharge:** | | |
| **Date of most recent stroke:** | |  | | |
| **General medical and stroke history:**  i.e. CVA dates, complications and co-morbidities that may restrict exercise/daily activities | |  | | |
| **Patient has or is susceptible to:** | **Hearing impairment**  **Impaired memory**  **Visual impairment**  **Impaired alertness** | | **Hemiparesis**  **Shoulder subluxation**  **Stroke related pain**  **MSK pain** | **Arrhythmia**  **Receptive Dysphasia**  **Expressive Dysphasia**  **Dysarthria** |

**ABSOLUTE CONTRAINDICATIONS – Do NOT refer**

**People with any current severe, UNSTABLE/UNCONTROLLED, condition.**

* **Resting systolic blood pressure >180mmHg**
* **Resting diastolic blood pressure >100mmHg**
* **Recent myocardial infarction (MUST have completed Phase 3 Cardiac rehab)**
* **New (< 1 month) or uncontrolled angina, or if it occurs at rest or at lower levels of exertion than normal**
* **New (< 3 months) or unstable diabetes and blood levels > 13mmol**
* **A recent change in resting ECG suggesting MI**
* **Symptomatic severe aortic stenosis**
* **Acute myocarditis or pericarditis**
* **Suspected or known dissecting aneurysm >4cm**
* **Unstable or acute cardiac event with fluid retention, excessive breathlessness, rapid weight gain, leg swelling or excessive tiredness**
* **New (< 3 months) or uncontrolled arrhythmias**
* **Uncontrolled resting tachycardia > 100bpm**
* **Experiences pain, dizziness or excessive breathlessness during exertion**
* **Symptomatic hypotension (during exercise) - Fall in SBP >20mg/Hg or DBP >10mg/Hg within 3 mins of standing**
* **Acute pulmonary embolus or infection**
* **Febrile illness or acute infection**
* **Other rapidly terminal illness**
* **Acute uncontrolled psychiatric/cognitive illness**
* **Recent injurious fall without medical assessment**

**The patient does NOT have any of the above contraindications**  **(tick to confirm)**