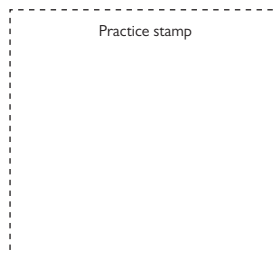


Everyone Active Referral Form



To be completed by referrer.

Please use black ballpoint/ink and block capitals.

Patient details

Surname: Forename: Date of Birth:

Address:

Postcode:

Telephone number: Ethnicity:

Details of referrer

Referrer/GP's name: Position:

Address:

Postcode:

Telephone number:

Reason for referral:

Clinical diagnosis and/or current problems - all conditions must be stable

- | | |
|--|---|
| <input type="radio"/> Overweight (BMI>25) | <input type="radio"/> Early symptomatic HIV |
| <input type="radio"/> Obese (BMI>30) | <input type="radio"/> Osteoporosis |
| <input type="radio"/> Type 2 diabetes (diet controlled) | <input type="radio"/> Physical disabilities (if this one is ticked there needs to be a place for more information about the disability) |
| <input type="radio"/> Osteoarthritis | <input type="radio"/> Stroke (not within the last 3 months) |
| <input type="radio"/> High normal blood pressure | <input type="radio"/> Parkinson's |
| <input type="radio"/> Stage one hypertension (medication controlled) | <input type="radio"/> Multiple Sclerosis (stable) |
| <input type="radio"/> Mild depression/anxiety | <input type="radio"/> Controlled diabetes type 1 or type 2 |
| <input type="radio"/> Moderate depression/anxiety | <input type="radio"/> COPD (without ventilatory limitation) |
| <input type="radio"/> Asthma | <input type="radio"/> Chronic fatigue syndrome |
| <input type="radio"/> Mild skeletal and muscular injuries. | <input type="radio"/> Fibromyalgia |
| <input type="radio"/> Back pain | <input type="radio"/> Moderate RA/OA |
| <input type="radio"/> Seropositive HIV | <input type="radio"/> Other: |

Medication:

- | | |
|---------|---------|
| 1. | 5. |
| 2. | 6. |
| 3. | 7. |
| 4. | 8. |

continued over...

Blood Pressure: BMI:

Please indicate whether the following will be affected during exercise by the patient's current medication and or medical condition:

☐ Heart Rate ☐ Pain

Please indicate if the patient is susceptible to any of the following conditions:

- | | | |
|---|--|--|
| <input type="radio"/> Arrhythmia | <input type="radio"/> Abnormal muscle tone | <input type="radio"/> Infection |
| <input type="radio"/> Hypoglycemia | <input type="radio"/> Impaired alertness | <input type="radio"/> Impaired cognition |
| <input type="radio"/> Urinary frequency | <input type="radio"/> Dizziness, falls | <input type="radio"/> Angina |
| <input type="radio"/> Joint pain | <input type="radio"/> Skin irritations, rashes | |

Specific exercises/approaches to be included:

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Specific exercises/approaches not to be included:

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"I the patient give my explicit consent for any relevant clinical information about my health to be transferred to the scheme coordinator and referral instructor".

Patient's signature: Date:

"I the referrer have checked the referral criteria and deem my patient appropriate to take part in the scheme".

Referrer's signature: Date:

ADMIN ONLY: To be completed by Everyone Active team

Centre: Risk level: Date received:



Everyone Active manages
these facilities in partnership
with the Borough of Poole.

