Everyone Active Referral Form

Practice stamp

everyone ACTIVE

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

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

Medication:

1. .....
2. .....
3. .....
4. .....
5. .....
6. .....
7. .....
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:

- ☐ Arrhythmia
- ☐ Hypoglycemia
- ☐ Urinary frequency
- ☐ Joint pain
- ☐ Abnormal muscle tone
- ☐ Impaired alertness
- ☐ Dizziness, falls
- ☐ Skin irritations, rashes
- ☐ Infection
- ☐ Impaired cognition
- ☐ Angina

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: .....

Borough of Poole

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

NHS Dorset Clinical Commissioning Group

www.everyoneactive.com