**Healthcare professionals:** on completion of this form please give it to your patient so that they are able to make contact with us to book a first assessment at a leisure centre or on 023 8200 0299

Please complete the form with ALL relevant details to enable the patient to participate in the physical activity referral programme.

Patient name:       DOB:

Tel:       Email:

Address:

Postcode:

# To confirm your patient is suitable for the programme please complete the following:

Patient currently has a clinically diagnosed medical condition Yes [ ]

Patient understands the referral scheme 12-week structure and pricing Yes [ ]

The patient’s medical condition is stable and controlled Yes [ ]

The patient is currently inactive (<30 mins of moderate activity a week) Yes [ ]

**Referral programme:** ActiveLifestyles 12 week [ ]  COPD [ ]  Cardiac Phase 4 [ ]  Falls prevention [ ]  Escape Pain [ ]  Cancer Rehab [ ]

**Primary referral condition:**

**Details of condition:**

# Current health conditions (please tick all that apply):

Hypertension [ ]  High Cholesterol [ ]  CHD/CVD/CCF [ ]  Obesity [ ]  COPD [ ]  Mental Health [ ]

Stroke [ ]  Cancer [ ]  Osteoporosis [ ]  Arthritis OA [ ]  RA [ ]  Parkinsons [ ]

Asthma [ ]  Neurological Disorder [ ]  Diabetes: Type I [ ]  Type II [ ]  Cardiac PH4 [ ]  Falls risk [ ]

Other (please state)

**Medication** (please provide a list of all current medications)

# Medical considerations affecting the patient’s ability to exercise?

#

**Baseline Measures** (please complete the following):

BP Systolic       BP Diastolic       BMI

|  |  |
| --- | --- |
| I refer this patient to the Physical Activity Referral Scheme under the terms and conditions set out in the referral guide. |  |
| Referrer signature       | **Practice stamp** |  |
| Date       |  |
| Print name/practice/pharmacy      . |  |
| **Referrer position** GP [ ]  Practice Nurse [ ]  Consultant [ ]  Health Visitor [ ]  Physio [ ]  |  |
| Pharmacist [ ]  (please tick as appropriate) |  |

# Patient consent

I agree to the release of my medical details to Freedom Leisure, I understand that confidentiality is assured. I understand that I am responsible for my own action at all times and that I am participating in the scheme voluntarily and that I am able to withdraw from the scheme at any time.

Signature ....................................................................................................................................... Date.....................................................................

# Applemore Health and Leisure Claypits Lane SO45 5TN

# Lymington Health and Leisure North Street SO41 8FZ

# New Milton Health and Leisure Gore Road BH25 6RR

# Ringwood Health and Leisure Parsonage Barn Lane BH24 1PX

# Totton Health and Leisure Water Lane SO40 3GX

023 8200 0299
freedom-leisure.co.uk