

HEALTH PROFESSIONAL PHYSICAL ACTIVITY REFERRAL FORM

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| Name (block capitals):­ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: ­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_  Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tel no: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Reason for Referral:  CONDITION SPECIFIC (e.g. CHD, Stroke, Osteoporosis, Hip & Knee) WEIGHT MANAGEMENT MENTAL HEALTH  GREEN HEALTH MOVEMORE (Cancer Rehab) INVIGOR8 (Falls Prevention) POST COVID-19 RECOVERY |

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| **MEDICAL REFERRAL** | | |
| Diagnosis:  Date:  Complications/Comments:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Current angina Y/N  GTN daily Y/N  Pain on exertion Y/N  Breathlessness on exertion Y/N  Heart irregularities Y/N  Hypertension Y/N  CVA/Dizziness Y/N  Claudication Y/N | Frequency or severity increasing  Y/N  Y/N  Y/N  Y/N  Y/N  **If ‘YES’ not suitable for referral** |
| **MEDICAL HISTORY**  Anxiety/Depression Y/N Epilepsy Y/N Ortho/musculo skeletal problems Y/N  COAD/Asthma Y/N Hypertension Y/N Diabetic Type 1 Y/N  Diabetic Type 2 NIDD Y/N Diabetic Type 2 IDD Y/N Previous positive COVID-19 test Y/N  Cancer Y/N  BP Reading:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Diagnosis \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Treatment/comments\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    **CURRENT MEDICATION**  Statin Warfarin/Aspirin Beta Blockers Ace Inhibitor Antidiabetic drug Insulin  \*Others please specify: ­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
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| Is there any history of risk or vulnerability for the applicant that can present difficulties or safety issues for him/her or others?  YES                                            NOT TO MY KNOWLEDGE  Are you aware of any potential or actual issues of risk or vulnerability in relation to Child Protection, Protection of Vulnerable Adults or any other legislation?  YES                              NOT TO MY KNOWLEDGE  **REFERRER**  I agree that this patient is likely to benefit from increasing physical activity with advice from Active North Ayrshire.  GP Cardiac Physio Consultant Health Professional  **Practice Address/Stamp:**    Date:­\_\_\_\_\_\_\_\_\_\_\_\_ Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| **PRIVACY AND DISCLAIMER**  We take your privacy seriously and will use your personal information out of legitimate interest to administer both your account and to provide the products and services you have requested from us. Your data will be shared as appropriate with third parties for agreed data processing and for the collection of subscription fees if applicable. Any exceptions to this will be with your prior consent. Please refer to our privacy policy at [www.kaleisure.com](http://www.kaleisure.com) for more details.  I agree that the above information may be passed on to Active North Ayrshire. My participation in the exercise sessions is totally voluntary. I am responsible for monitoring my own condition throughout the sessions and, should any unusual symptoms occur, I will stop exercising immediately and inform the instructor/GP of these symptoms. If I am aware of any change in my health that could affect my ability to exercise, I will get advice from my GP before exercising.  ***Patient’s signature***:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ***Date***:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |

This form can be securely emailed to [activelifestyles@kaleisure.com](mailto:activelifestyles@kaleisure.com) or posted to the address below.

FOR ADDITIONAL SUPPLY OF FORMS, PLEASE CONTACT: ACTIVE LIFESTYLES OFFICER, AUCHENHARVIE LEISURE CENTRE, SALTCOATS ROAD, STEVENSTON KA20 3JR. TEL: 01294 605128 EMAIL: [activelifestyles@kaleisure.com](mailto:activelifestyles@kaleisure.com)