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| --- |
| **CLIENT’S DETAILS** |
| **Full Name** |  | **Gender** | Male [ ]  Female [ ]  |
| **Address** |  |
| **Date of Birth** |  | **Contact Number** |  |
| **GP Surgery** |  |
| **GP’s Name** |  |
| **GP Telephone** |  |
|  |
| **Please tick this box confirming there are no below contra-indications to exercise** [ ]   |
| Cardiomyopathy  | Resting systolic BP > 180mmHg/100mmHg |
| Suspected or known aneurysm | Uncontrolled resting tachycardia ≥ 100bpm |
| Febrile illness/Acute systemic illness (e.g. cancers) | Severe breathlessness or dizziness  |
| New or uncontrolled arrhythmias | Uncontrolled diabetes |
| Uncontrolled/unstable angina | Unstable or acute heart failure |
| Dementia, Alzheimer’s or severe cognitive impairment (unable to follow simple instructions) |
|  |
| **Cautions, recommendations, or special considerations for exercise – please list below** |
|  |
|  |
|  |
| **MEDICAL HISTORY – please tick all relevant boxes** |
| Postural Hypotension | [ ]  | Visual Impairment | [ ]  | OA – please specify | [ ]   |
| Angina  | [ ]  | Hearing Impairment | [ ]  | RA – please specify | [ ]   |
| Arrhythmia | [ ]  | Osteoporosis  | [ ]  | Cancer  | [ ]   |
| Asthma/COPD | [ ]  | DM | [ ]  | MSK – please specify | [ ]   |
| HTN | [ ]  | MS | [ ]  | Joint replacement(s) – please specify | [ ]   |
| PD | [ ]  | CVA | [ ]  |
| Other – please specify  |  |
|  |
| **MEDICATION – please list or attach a list to the email when sending the referral form**  |
|  |  |  |  |
|  |  |  |  |
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|  |
| **SOCIAL HISTORY – please tick all relevant boxes** |
| **Mobility indoors****(+/- aid)** |  | **Mobility outdoors****(+/- aid)** |  |
| **Transfers independently**  | Yes [ ]  No [ ]  | **Uses stairs** | Yes [ ]  No [ ]  |
|  |
| **FALLS HISTORY - please tick all relevant boxes** |
| **Number of falls in last 12 months**  |  | **Fear of falling** | Yes [ ]  No [ ]  |
| **Previous injuries (inc. fractures)** |  | **Family history of osteoporosis** | Yes [ ]  No [ ]  |
| **Sit to stand from a chair without arms?** | Yes [ ]  No [ ]  | **Can they get up off the floor after a fall?** | Yes [ ]  No [ ]  |
|  |
| **REFERRER’S DETAILS** |
| **Full name** |  |
| **Role or relationship to client** |  |
| **Telephone** |  |
| **Email** |  |

Please return this form to **enquiries@activityismedicine.co.uk**